

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

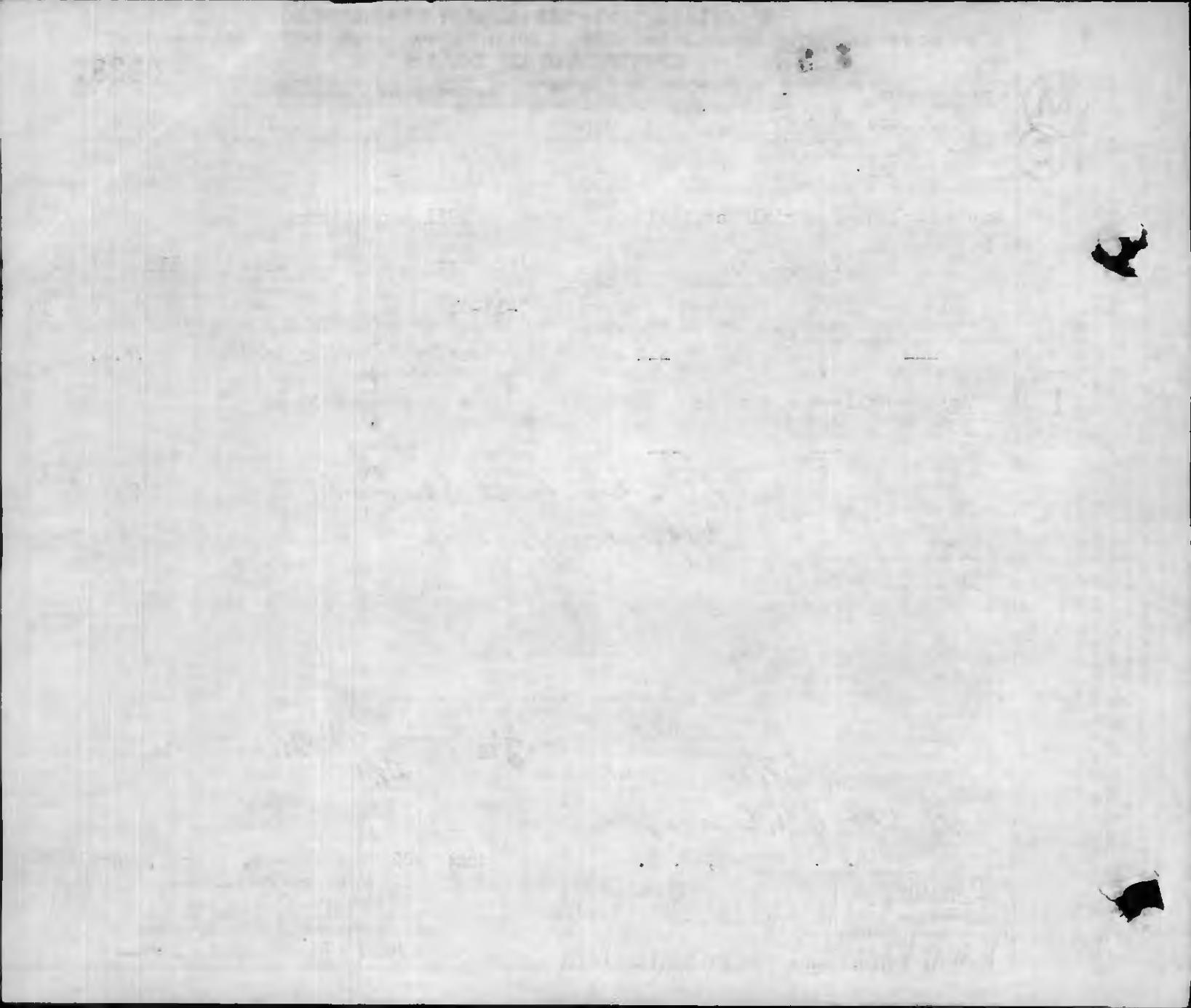
CERTIFICATE OF DEATH

08281

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 1 month					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital							
3. NAME OF DECEASED (Type or print)	First (Baby boy)	Middle Alexander	Last July				
4. DATE OF DEATH	Month 13	Day 19	Year 61				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-13-61				
9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours 6 30				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---					
11. BIRTHPLACE (County & State, or foreign country) Prince Georges, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Arthur Wallace Alexander							
14. MOTHER'S MAIDEN NAME Barbara Mae Hartman							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. --- 17. INFORMANT Hospital Records Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prunten birth (25 week) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Asphyxia failure DUE TO (b) 6 weeks DUE TO (c) 12 h							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Death	20f. (City or town) Laurel	(County) Maryland	(State) MD	
21. I certify that (I) (This Hospital) attended the deceased from July 13 , 1961, to July 13 , 1961, that (I) (we) last saw the deceased alive on July 13 , 1961, and that death occurred at PM , from the causes and on the date stated above.				22b. DATE SIGNED			
22a. SIGNATURE R. S. McCeney				ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) R. S. McCeney, M. D.				22d. ADDRESS 402 Main Street, Laurel, Maryland			
23a. FUNERAL CREMATION REMOVAL AGENT July 15, 1961		23b. DATE THEREOF July 15, 1961		23c. NAME OF CEMETERY OR CREMATORIAL Laurel		23d. LOCATION (City, town or county) Laurel, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Laurel, Md.		ADDRESS Laurel, Md.		25a. REC'D BY REGISTRAR JUL 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon layers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8289

CERTIFICATE OF DEATH

08282

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 2 mo., 14 da		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1243 10th St., N.W.	
e. NAME OF DECEASED (Type or print) Robert H. Askins		Last 7	4. DATE OF DEATH Month 31
First R		Middle H.	Day 19
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3/12/04		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Standard Paving Co.	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Askins		14. MOTHER'S MAIDEN NAME Mary Lincoln	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service) Unknown		16. SOCIAL SECURITY NO. 214-03-9265	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). Pulmonary embolus			
DUE TO 465 X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of left lung metastatic, primary site unknown, resected left pneumonectomy, 7/5/61; pyloroplasty, 7/26/61		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/17 5:00 , 1961 to 7/31 , 1961, that (I) (we) last saw the deceased alive on 7/31 , 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 7/31/61	
22e. SIGNATURE Moe Weiss		M.D.	ATTENDING PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23e. BURIAL, CREMATION, REMOVAL (Specify) Burial July 31st 1961		23c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial	
23d. LOCATION (City, town or county) Gaudy Spring, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE E.B. Guggo 624 1222 7th St. N.E.		25a. REC'D BY REGISTRAR DATE AUG 4 '61	
ADDRESS W.H. Beaumont Home		25b. REGISTRAR'S SIGNATURE DATE Aug 4 '61	

283

M

several months

about 50 years

about 100 years

(Signature)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8290

CERTIFICATE OF DEATH

Reg. Dist. No.

08283

1. PLACE OF DEATH
a. COUNTY

PRINCE GEORGES

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CHEVERLY

c. LENGTH OF STAY IN lb

2 years

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION Ad-Sacordia

2601 CHEVERLY AVENUE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

MARYLAN D

b. COUNTY

MONTGOMERY

3. NAME OF
DECEASED
(Type or print)

First Raymond

Middle J.

Last Augusterfer

4. DATE
OF
DEATH

Month JULY

Day 19

Year 1961

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9-9-79

9. AGE (In years
last birthday)

81 yrs.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED ENGINEER

10b. KIND OF BUSINESS OR INDUSTRY

U.S. GOV'T.

11. BIRTHPLACE (State or foreign country)

WASHINGTON, D. C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN AUGUSTERFER

SUSAN GADDIS

14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

NO

16. SOCIAL SECURITY NO.

INFORMANT

Address

MISS RITA M. AUGUSTERFER Same as #

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cerebral Thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

2 weeks

332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Generalized Arteriosclerosis 5 yrs.

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Diabetes Mellitus

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 1920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 11/7, 1954, to 7/19, 1961, that I last saw the deceased alive on 7/15, 1961, and that death occurred at 2:45 P.M. from the causes and on the date stated above.

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

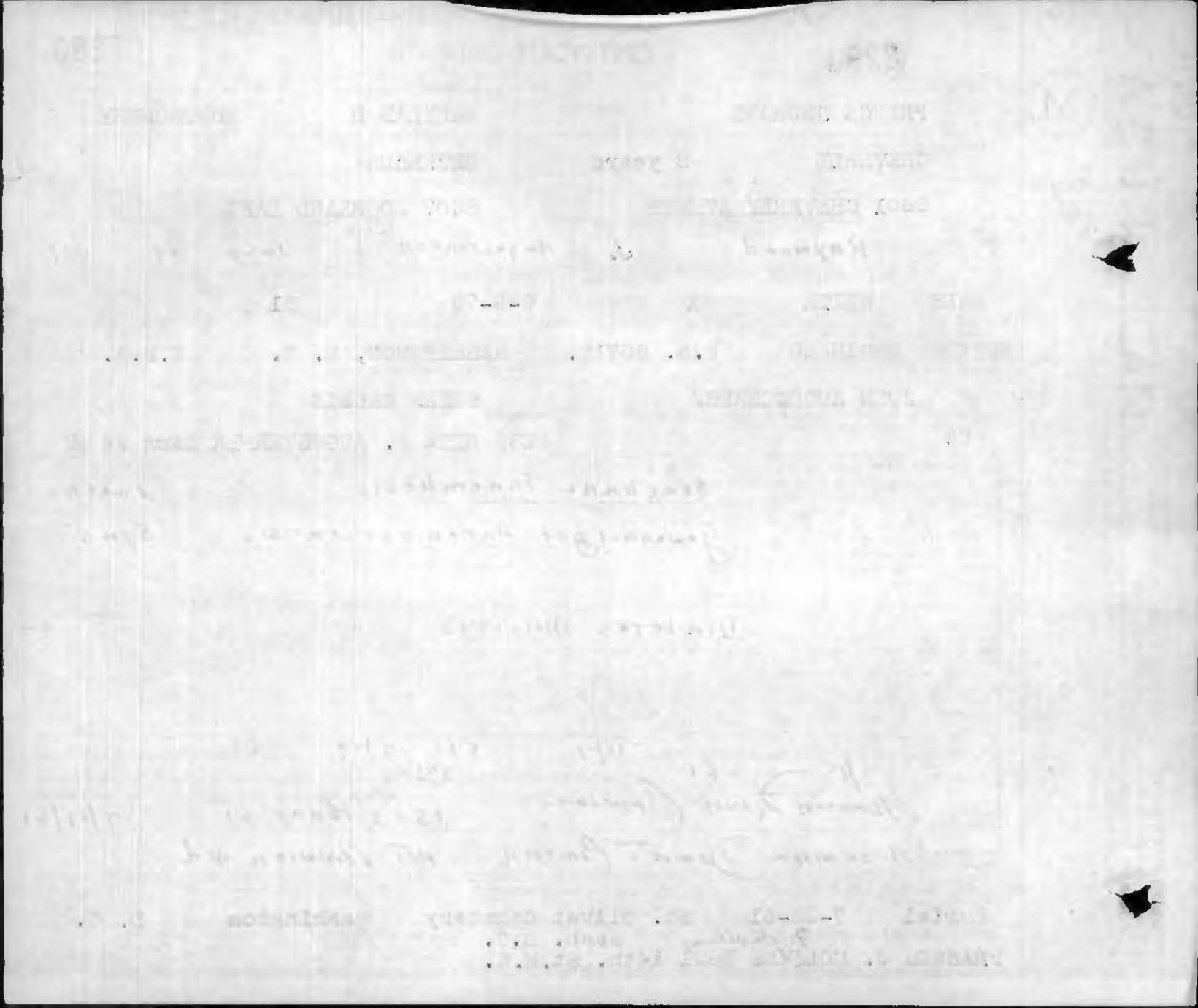
ADDRESS (Street, city or town, state)

DATE SIGNED

7/19/61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7-22-61 22c. NAME OF CEMETERY OR CREMATORI Mt. Olivet Cemetery 22d. LOCATION (City, town, or county) Washington (State) D. C.

23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS Wash. D.C. 240. REC'D BY REGISTRAR JUL 24 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Thrane DATE JUL 24 '61



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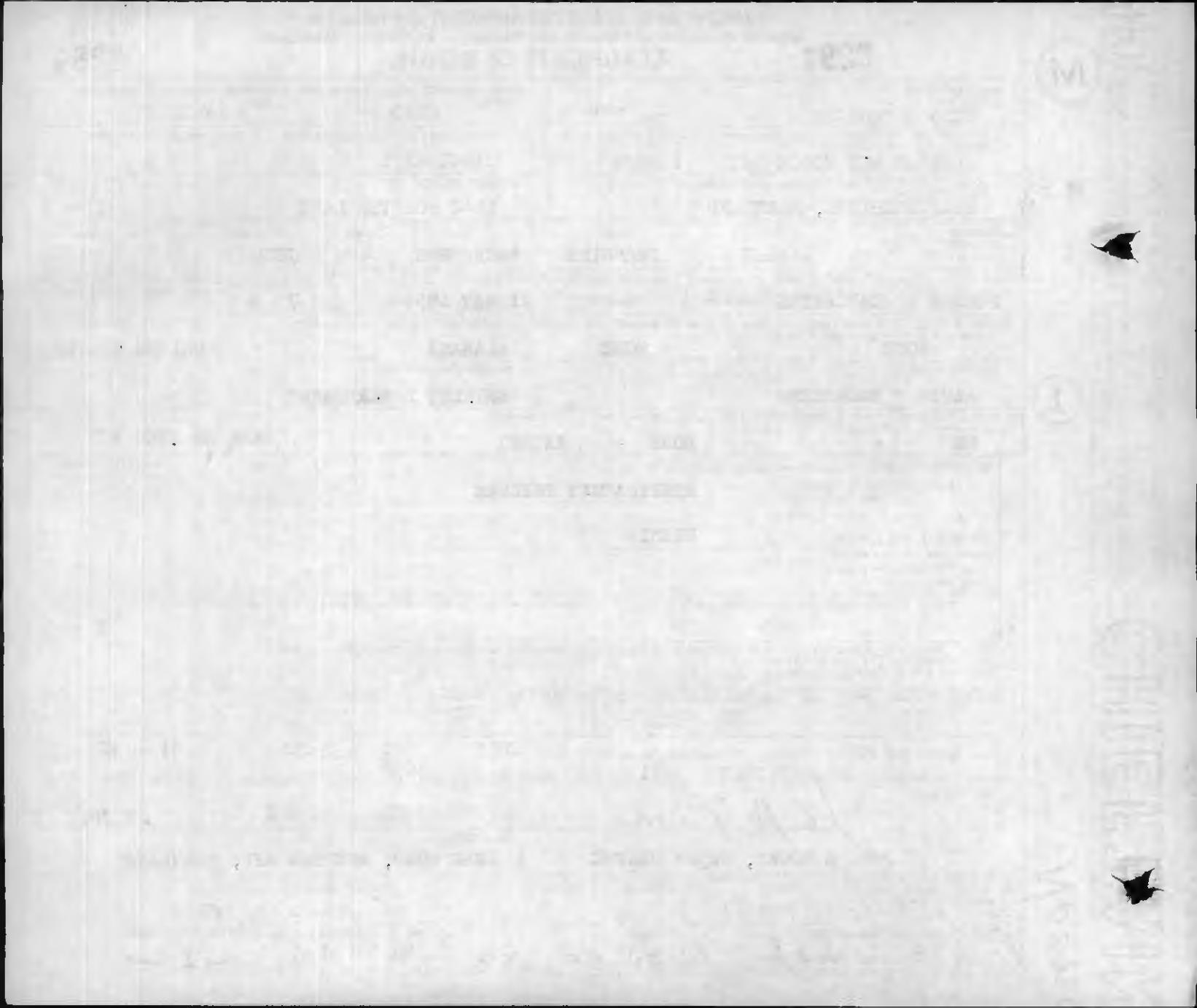
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08284

8291

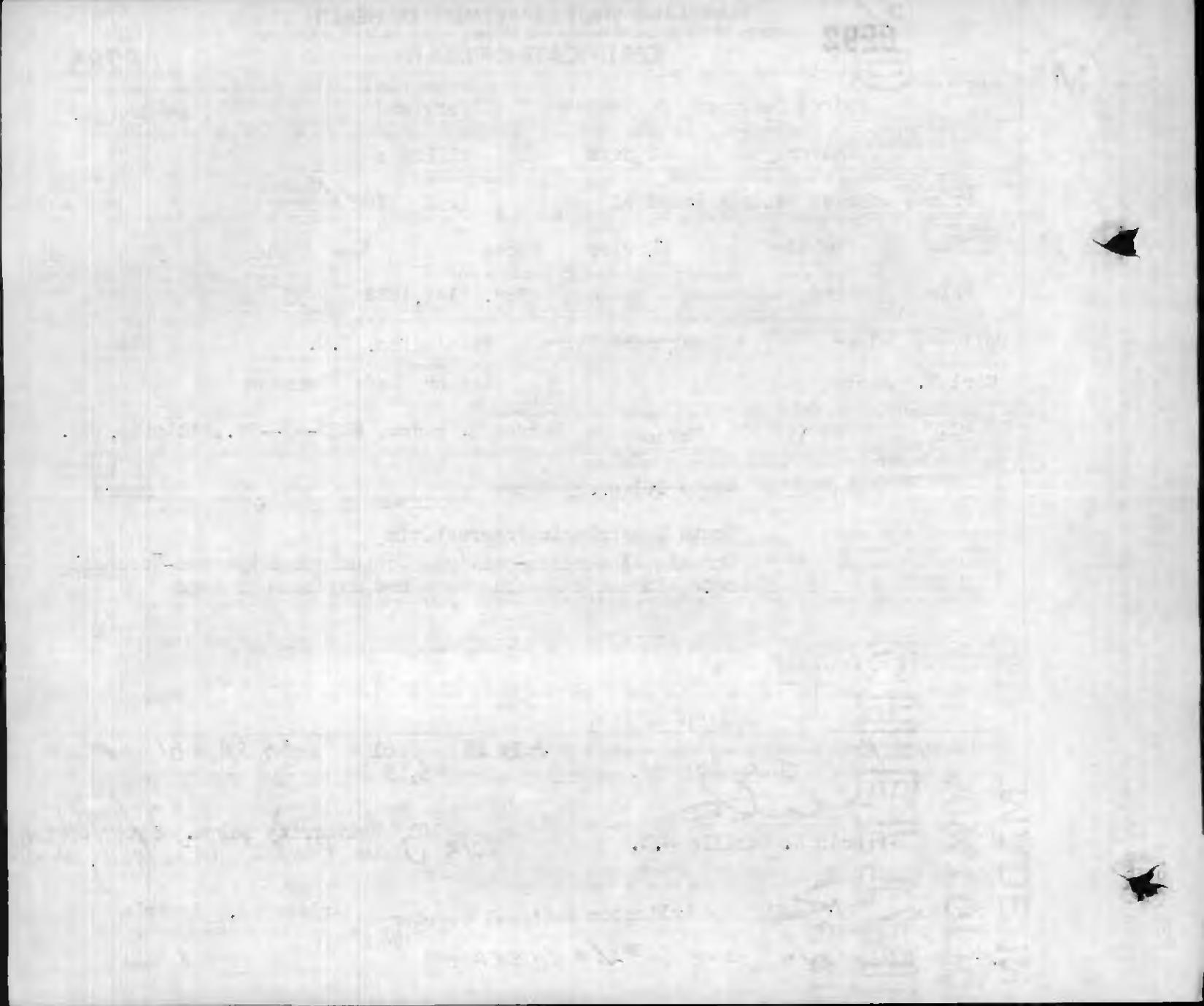
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE OHIO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN lb 1 HOUR	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL, MARYLAND		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CINCINNATI	
3. NAME OF DECEASED (Type or print) LESLIE JEANNINE BACKHERMS		4. DATE OF DEATH JULY 7 1961	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 MAY 1954
9. AGE (In years lost birthday) 7 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) ALABAMA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ALVIN T BACKHERMS		14. MOTHER'S MAIDEN NAME SHIRLEY L BERNHARDT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT FATHER		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 792X Conditions, if any, which gave rise to immediate cause (a), slating the underlying cause last. (b) DUE TO UREMIA (c) DUE TO	
		19. INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (We) attended the deceased from 7 JULY 1961 to 7 JULY 1961 , that (We) last saw the deceased alive on 7 JULY 1961 , and that death occurred at 845A , from the causes and on the date stated above.		22b. DATE SIGNED 7 JULY 61	
22a. SIGNATURE <i>John A. Moore</i>		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D.	
22c. PHYSICIAN'S NAME (Type) JOHN A. MOORE, Major USAFMC		22d. ADDRESS USAF HOSP, ANDREWS AFB, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10 July 1961	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 816 A ST. N.E., DC 2		23d. LOCATION (City, town, or county) CINCINNATI OHIO	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Liselli Funeral Home Inc.</i>		25a. REC'D BY REGISTRAR DATE JUL 10 '61	
		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Thomas</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb 2 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital						d. STREET ADDRESS 1412 52nd Place Street											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Melvin Charles Bacon		First	Middle	Last	4. DATE OF DEATH July 30 1961	Month	Day	Year	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21st, 1922	9. AGE (In years last birthday) 38 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delivery Helper			10b. KIND OF BUSINESS OR INDUSTRY Department Store			11. BIRTHPLACE (State or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME Carl W. Bacon						14. MOTHER'S MAIDEN NAME Esther Wade Pearson											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. WW 11			17. INFORMANT Warren H. Bacon, 5202--N--St., Hillside, Md.			Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema																	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 322.0																	
(b) Acute Hemorrhagic Pancreatitis																	
DUE TO Chronic Alcoholism-Multiple Contusions & Ecchymoses-Cerebral Edema																	
(c) Acute Alcoholic Intoxication and delerium Tremens																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Balivo, Silver Spring	(County) 1013 University Blvd. E.	(State) 1013 Univ Blvd. E. Silver Spring, Md.								
21. I certify that Francis X. Carillo M.D. attended the deceased from July 28 1961 to July 30 1961 , that we last saw the deceased alive on July 30 1961 , and that death occurred at 5:15 AM from the causes and on the date stated above.																	
22a. SIGNATURE Francis X. Carillo M.D.						22b. DATE SIGNED 20/07/61											
22c. PHYSICIAN'S NAME (Type) Francis X. Carillo M.D.						22d. ADDRESS 1013 University Blvd. E. Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/2/1961		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery		23d. LOCATION (City, town, or county) Arlington, Virginia		(State)									
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Inc.						25a. REC'D BY REGISTRAR AUG 2 '61						25b. REGISTRAR'S SIGNATURE Charles L. Thomas					
ADDRESS 517 11th St. N.W. Washington, D.C.						DATE											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8293

88286

CERTIFICATE OF DEATH

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M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		c. LENGTH OF STAY IN 1b <i>28 hrs.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) e. STATE <i>Maryland</i>		b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		d. STREET ADDRESS <i>3922 Oglethorpe Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Eugene Leland Memorial</i>		First <i>Baker</i>		Middle <i>Mary Katherine</i>		f. DATE OF DEATH <i>July 7 1961</i>	
3. NAME OF DECEASED (Type or print) <i>Baker</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 4, 1878</i>		9. AGE (In years last birthday) <i>83 yrs.</i>	
5. SEX <i>Fe</i>		6. COLOR OR RACE <i>White</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Name</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Laurel, Md.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Name</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Laurel, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard Loveloss</i>		14. MOTHER'S MAIDEN NAME <i>Bell</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Mae Gosnell (daughter)</i>	
						Address <i>Same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>42</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)							
cardiovascular collapse Dehydration Anorexia and old age							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e.) <i>Old age</i>							
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <i>7-6 1961</i> to... <i>7-7 1961</i> , that (I) (we) last saw the deceased alive on... <i>7-7 1961</i> , and that death occurred at <i>10P.M.</i> from the causes and on the date stated above.		22e. SIGNATURE <i>Ronald E. Krum</i>		M.D. ATTENDING PHYS. 22d. ADDRESS <i>4404 Queensbury Road, Riverdale, Md.</i>		22b. DATE SIGNED <i>7-7-61</i>	
22e. PHYSICIAN'S NAME (Type) <i>Ronald E. Krum, MD</i>		22d. ADDRESS <i>4404 Queensbury Road, Riverdale, Md.</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Tony Hill Cemetery Laurel Md.</i>		23d. LOCATION (City, town or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial July 10, 1961</i>		23b. DATE THEREOF <i>JULY 10 1961</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Tony Hill Cemetery Laurel Md.</i>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Hermit Donaldson 313 Talbot Ave Laurel Md.</i>		25a. RECD. BY REGISTRAR <i>Arthur S. Krum</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krum</i>		DATE <i>JUL 13 '61</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9 & 14 F. L. G. S. I. 7/24/61 iwk

8294

CERTIFICATE OF DEATH

Reg. Dist. No.

68287

1. PLACE OF DEATH o COUNTY		Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) B Rural (Friendly)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9035 Old Fort Rd. S.E.		e. STREET ADDRESS 9035 Old Fort Rd. S.E.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bailie Annie		Month Lost	Month Found	4. DATE OF DEATH July 14	Month Day Year 1961
5. SEX Female Colored		6 COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-15-86	9. AGE (In years and birthday) 74 yrs.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Prince Ge Co Md.	
13 FATHER'S NAME Robert Jackson		14 MOTHER'S MAIDEN NAME Nancy unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15 WAS DECEASED EVER IN U. S. ARMED FORCES (Yes or no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Agness Beck, Daughter 9035 Old Fort Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 44 SX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Acute Cardiac Arrest DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
		Acute Gouty Arthritis DUE TO		6 months	
		Hypertensive Heart Disease (c)		5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Cerebral Art-Sclerosis + Hemiplegia 5 yrs					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-27, 1961, to 7-14, 1961, that I last saw the deceased alive on 7-12-61, 1961, and that death occurred at 3:05 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE Anna Coyne Todd M.D.		DATE SIGNED 7519 Broadview Rd. SE			
PHYSICIAN'S NAME (Type) Anna Coyne Todd, M.D.		Wash. 22, D.C. (or N.Y., etc.)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-18-61		22c. NAME OF CEMETERY OR CREMATORIAL Grace Ch. Cem.	
22d. LOCATION (City, town or county) Friendly				(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hall Bros. 621 1/2 Fla. ave NW		ADDRESS		24a. REC'D BY REGISTRAR JUL 17 '61	
				24b. REGISTRAR'S SIGNATURE Curtis S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8295

CERTIFICATE OF DEATH

Reg. Dist. No. 02282

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE <i>MARYLAND</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	c. LENGTH OF STAY IN 1b <i>7 yrs.</i>	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	c. LENGTH OF STAY IN 1b <i>5</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6908-18½ Ave.</i>	d. STREET ADDRESS <i>6908-18½ Ave.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>HELENE</i>	First <i>ELAINE M.B.</i>	Middle <i>BALLEW</i>	Last 4. DATE OF DEATH Month <i>July</i> Day <i>30</i> Year <i>1961</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 15, 1913</i>		
9. AGE (In years lost birthday) yrs. <i>48</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales Clerk, Hecht's Dept. Store</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>New York City N.Y.</i>	11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	13. FATHER'S NAME <i>Cather Emmanuel Briggs</i>				
14. MOTHER'S MAIDEN NAME <i>Catherine Konalty</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>1938-03-6-3/16</i>				
16. SOCIAL SECURITY NO. <i>138-03-6316</i>	17. INFORMANT <i>Helen L. Ballew, Husband</i>	Address <i>above</i>	INTERVAL BETWEEN ONSET AND DEATH <i>3-4 months</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <i>Carcinoma of Breast with Metastasis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>May, 1954</i> , to <i>July 30, 1961</i> , that I last saw the deceased alive on <i>July 28, 1961</i> , and that death occurred at <i>2 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>7105 Ridge Rd.</i> DATE SIGNED <i>Robert B. Troy</i>					
ACTUAL SIGNATURE <i>Robert B. Troy</i>	PHYSICIAN'S NAME (Type) <i>ROBERT B. TROY</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/2/61</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington, Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home Inc.</i>		ADDRESS <i>16th Rainier Rd.</i>	24a. REC'D BY REGISTRAR DATE AUG 3 '61	24b. REGISTRAR'S SIGNATURE <i>Robert B. Troy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C8289

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN 1b Prince George's General		d. STREET ADDRESS 5410 40th Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First A.	Middle Bateman
4. DATE OF DEATH July 5 1961	Month July	Day 5	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24. 1890
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry W. Price		14. MOTHER'S MAIDEN NAME Cornelia Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. no	
17. INFORMANT husband		Address George E. Bateman, 5410 40th Ave., Hyatts-	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO cerebral hemorrhage INTERVAL BETWEEN ONSET AND DEATH 192hr	
DUE TO Cerebral Arteriosclerosis (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m p. m July 5 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 5 1961 , that (I) (we) last saw the deceased alive on July 5 1961 , and that death occurred at 1058 1/2 A.M. from the causes and on the date stated above.		22b. DATE SIGNED July 5, 1961	
22a. SIGNATURE Leon R. Levitsky, M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M.D.		22d. ADDRESS 3408 Rhode Island Ave., Mt. Rainier, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Rock Creek Cemetery		23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery	
23b. DATE THEREOF 7/7/61		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The J. H. Hines Co., 2901-14th St. N.W.		25a. REC'D BY REGISTRAR DATE JUL 7 '61	
		25b. REGISTRAR'S SIGNATURE J. H. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8297

CERTIFICATE OF DEATH

Reg. Dist. No. 08290

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie High Bridge Md.		c. LENGTH OF STAY IN 1b RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bowie, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Norman Henry Beckett		First <i>Norman</i>	Middle <i>Henry</i>
4. SEX male	5. COLOR OR RACE white	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Sept 17, 1880		9. AGE (In years (at birthday) yrs.) 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agriculture		10b. KIND OF BUSINESS OR INDUSTRY U S Government	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Robert Beckett		14. MOTHER'S MAIDEN NAME Pumphrey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 55	
17. INFORMANT Eva Beckett		Address High Bridge Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO <i>Coronary Artery Disease with acute myocardial infarction - minute</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Atherosclerotic heart disease DUE TO <i>Generalized atherosclerosis</i> (c)			
INTERVAL BETWEEN ONSET AND DEATH Year			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 56 , to 7/16 , 19 61 , that I last saw the deceased alive on 7/15 , 19 61 , and that death occurred at 528 M., from the causes and on the date stated above			
ACTUAL SIGNATURE <i>James Kortz</i>		ADDRESS (Street, city or town, state) R E D Glenn Dale Md	
PHYSICIAN'S NAME (Type) <i>H. James Kortz</i>		DATE SIGNED 7/16/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/61	
22c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	24a. REC'D BY REGISTRAR JUL 24 '61
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Prince George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

MARYLAND

2 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
DECEASED
(Type or print)

Howard

5. SEX

6. COLOR OR RACE

Male

Colored

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

13. FATHER'S NAME

Hammond Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

10b. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

July 28, 1938

11. BIRTHPLACE (State or foreign country)

North Carolina

14. MOTHER'S MAIDEN NAME

Bell Armstrong

Address

9. AGE (In years, if under 1 year, last birthday) Months Days Hours Min.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

12. CITIZEN OF WHAT COUNTRY?



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
CERTIFICATE OF DEATH											
Reg. Dist. No. 08292											
1. PLACE OF DEATH a. COUNTY <i>PRINCE GEORGE'S</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>PRINCE GEORGE'S</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>LANHAM</i>				c. LENGTH OF STAY IN 1b <i>5 days</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RIVERDALE</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9205-3rd Street</i>								d. STREET ADDRESS <i>6120-54th Avenue</i>			
3. NAME OF DECEASED (Type or print) <i>ESTHER RUTH BEVANS</i>				First	Middle	Last	4. DATE OF DEATH <i>JULY 12 1961</i>				
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>OCT. 25, 1899</i>		9. AGE (In years last birthday) <i>61 yrs.</i>		10. IF UNDER 1 YEAR <i>Months Days Hours Min</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>WASH. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>GEORGE MELVIN LITTLE</i>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>577-14-3323</i>				17. INFORMANT <i>LILLIAN AUGUSTA GREENWELL</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>Carcinomatosis</i> DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of rectum</i> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>—</i>		(County) <i>—</i>	
21. I certify that I attended the deceased from <i>September, 1961</i> , to <i>July 12, 1961</i> , that I last saw the deceased alive on <i>July 11, 1961</i> , and that death occurred at <i>11:05 A.M.</i> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>4506 COLLEGE AVE</i>		DATE SIGNED <i>7/12/61</i>	
ACTUAL SIGNATURE <i>C. LOUIS MENDEL</i> M.D. <i>COLLEGE PARK MD</i> PHYSICIAN'S NAME (Type) <i>C. LOUIS MENDEL</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/14/61</i>		22c. NAME OF CEMETERY OR Crematory <i>Arlington National</i>				22d. LOCATION (City, town, or county) <i>Arlington,</i> (State) <i>Va.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>						ADDRESS <i>Hyattsville, Md.</i>		24a. REC'D BY REGISTRAR <i>JUL 17 '61</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
by the funeral director, or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8300

CERTIFICATE OF DEATH

03293

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. GeO's Co				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 6 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills, Maryland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				d. STREET ADDRESS 5009- Spring Drive S.E.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First LILLIAN	Middle KING	Last BIRD	4. DATE OF DEATH	Month July	Year 1961		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 20-July 1870	9. AGE (In years lost birthday) 90 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Mass.	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Martin Luther King				14. MOTHER'S MAIDEN NAME Annie Tibbetts				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service			16. SOCIAL SECURITY NO	17. INFORMANT Albert F. Bird	Address Same as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Stroke</i> <i>Accident</i> INTERVAL BETWEEN ONSET-AND DEATH <i>3 mos</i>								
DUE TO <i>High blood pressure</i> <i>Heart Disease</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> (c) <i>Diabetes</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Phenothiazine</i> <i>Aspirin</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc)		20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>July 1</i> , 1954, to <i>July 1</i> , 1961, that (I) (we) last saw the deceased alive on <i>July 2</i> , 1961, and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.								
22a. SIGNATURE <i>Lewis Parker</i>				M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>7-7-61</i>			
22c. PHYSICIAN'S NAME (Type) Lewis PARKER				22d. ADDRESS <i>521 1/2 Pawpaw St 8E</i>				
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-11-61</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Edgewood Cemetery</i>		23d. LOCATION (City, town, or county) <i>Nashua New Hampshire</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Sinclair Brothers</i>		ADDRESS <i>1661 Good Hope Road SE Washington DC</i>		25a. REC'D BY REGISTRAR <i>JUL 10 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Art & S. Kline</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

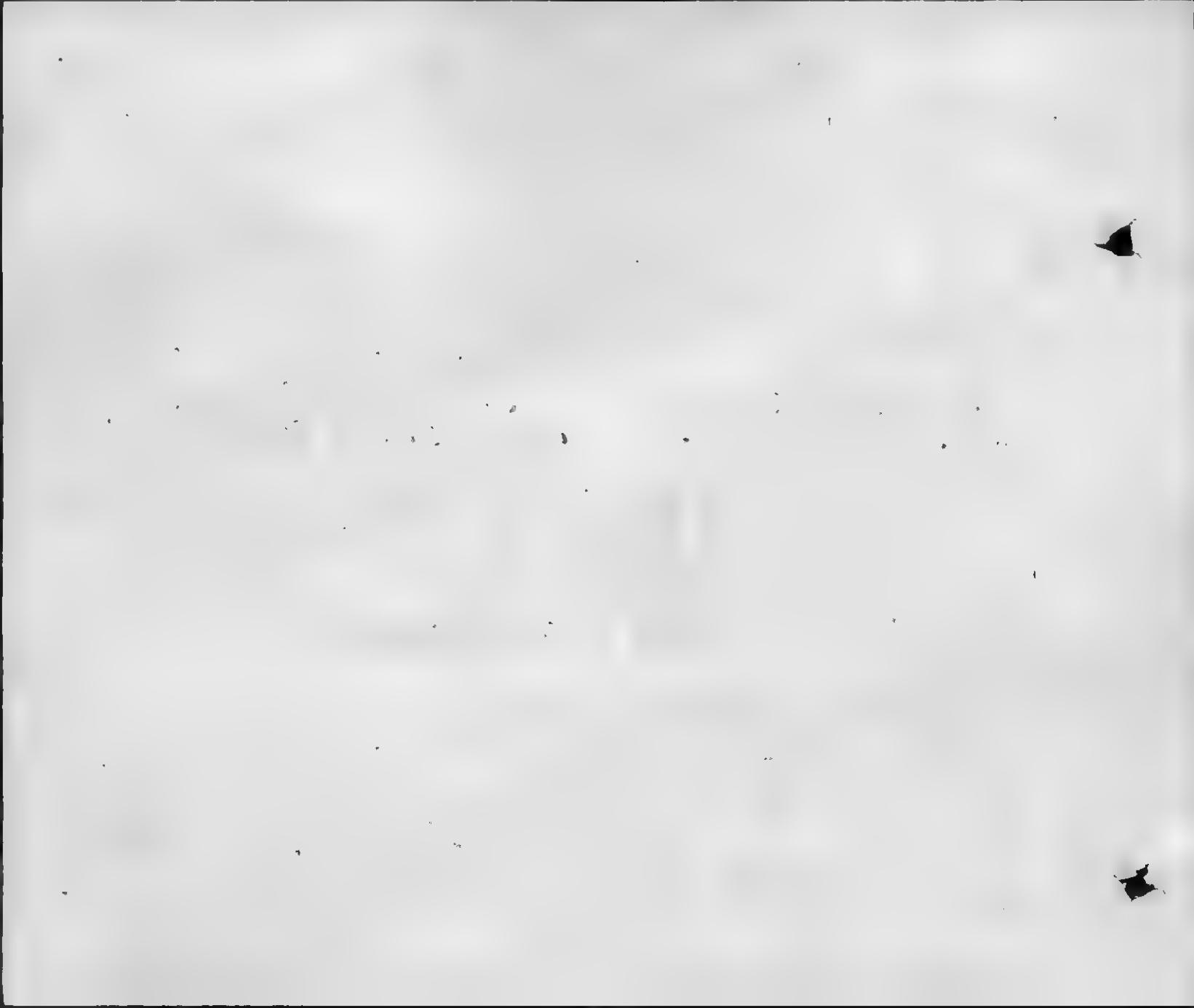
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8301

C8294

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Prince George's		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Maryland	Prince George's
Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	West Hyattsville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	59
Prince George's General		3104 Gumwood Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Middle Last	Month Day Year
Mary		E.	July 25 1961
4. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		White	8. DATE OF BIRTH
		WIDOWED <input checked="" type="checkbox"/>	April 2, 1889
9a. USWAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years) IF UNDER 1 YEAR last birthday	
Not employed		72 yrs.	Months Days
10. FATHER'S NAME		11. BIRTHPLACE (County & State, or foreign country)	
JAMES W. BURDINE		WASHINGTON, D. C. U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
UNKNOWN		NONE HARVEY L. SUPPLIE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Congestive Heart Failure	
DUE TO (b) DUE TO (c)		Hypertensive A. S. C-V Disease 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Diabetes Mellitus ; bronchopneumonia			
20a. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) (We) attended the deceased from to , 1961, that (I) (We) last saw the deceased alive on		22a. SIGNATURE	
22b. PHYSICIAN'S NAME (Type)		Leon L. Gallin	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL
Burial		7-28-1961	Arlington National
24. FUNERAL DIRECTOR'S SIGNATURE		23d. LOCATION (City, town or county) (State)	
W. W. Chambers Co. Inc.		Baltimore, Maryland	
ADDRESS		25a. REC'D BY REG STRAR	
5801 Cleveland Ave		25b. REGISTRAR'S SIGNATURE	
Beverlydale, Md.		DATE JUL 28 '61 Arthur S. Kress	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8302

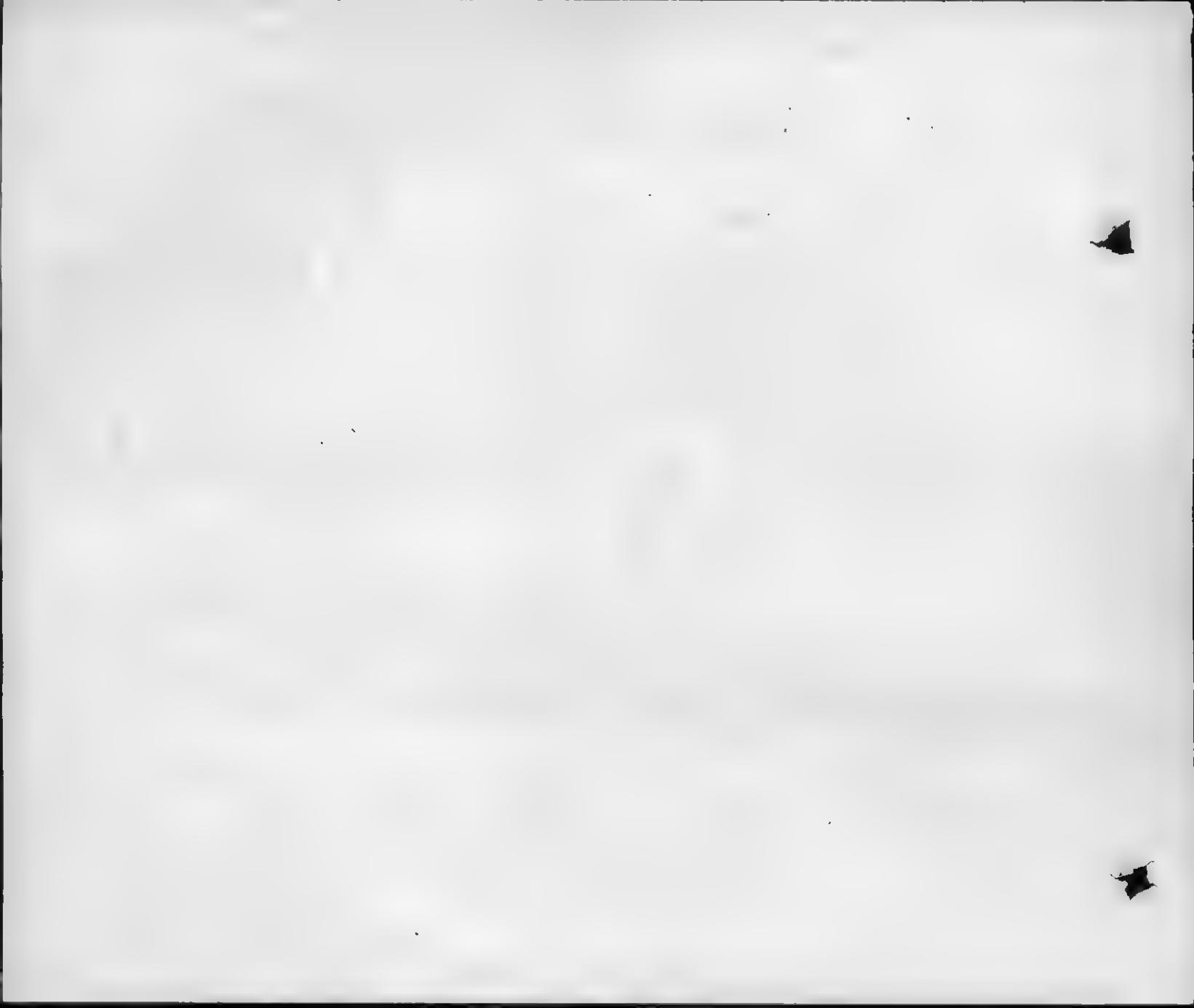
CERTIFICATE OF DEATH

08295

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Daniel</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>81 Laurel</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1103 Shaundan Place</i>		e. STREET ADDRESS <i>1103 Shaundan Place</i>	
3. NAME OF (Type or print)	First <i>Aubrey</i>	Middle <i>B.</i>	4. DATE OF DEATH <i>July 15 1961</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>January 5 1906</i>	9 AGE (In years at time of death 1st birthday) <i>55 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done along most of working life, even if retired) <i>Cahow Foreman Library of Congress Laurel Co. Md</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country)</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Edward Brown</i>		14. MOTHER'S MAIDEN NAME <i>Ella Sullivian</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>579-22-3504</i>	17. INFORMANT <i>Barbara J. Brown, Laurel, Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>052X</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Hypertension</i>			
DUE TO (b) DUE TO (c) <i>Aortic Aneurysm</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>19</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at <i>9A</i> M., from the causes and on the date stated above			
22a. SIGNATURE <i>Adelio Pierandrea'</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23c. DATE THEREOF <i>July 18, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Any Hill Cemetery Laurel, Md</i>		23d. LOCATION (City, town, or county) (State) <i>Laurel, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ed Will Danaher, Laurel, Md</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 20 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



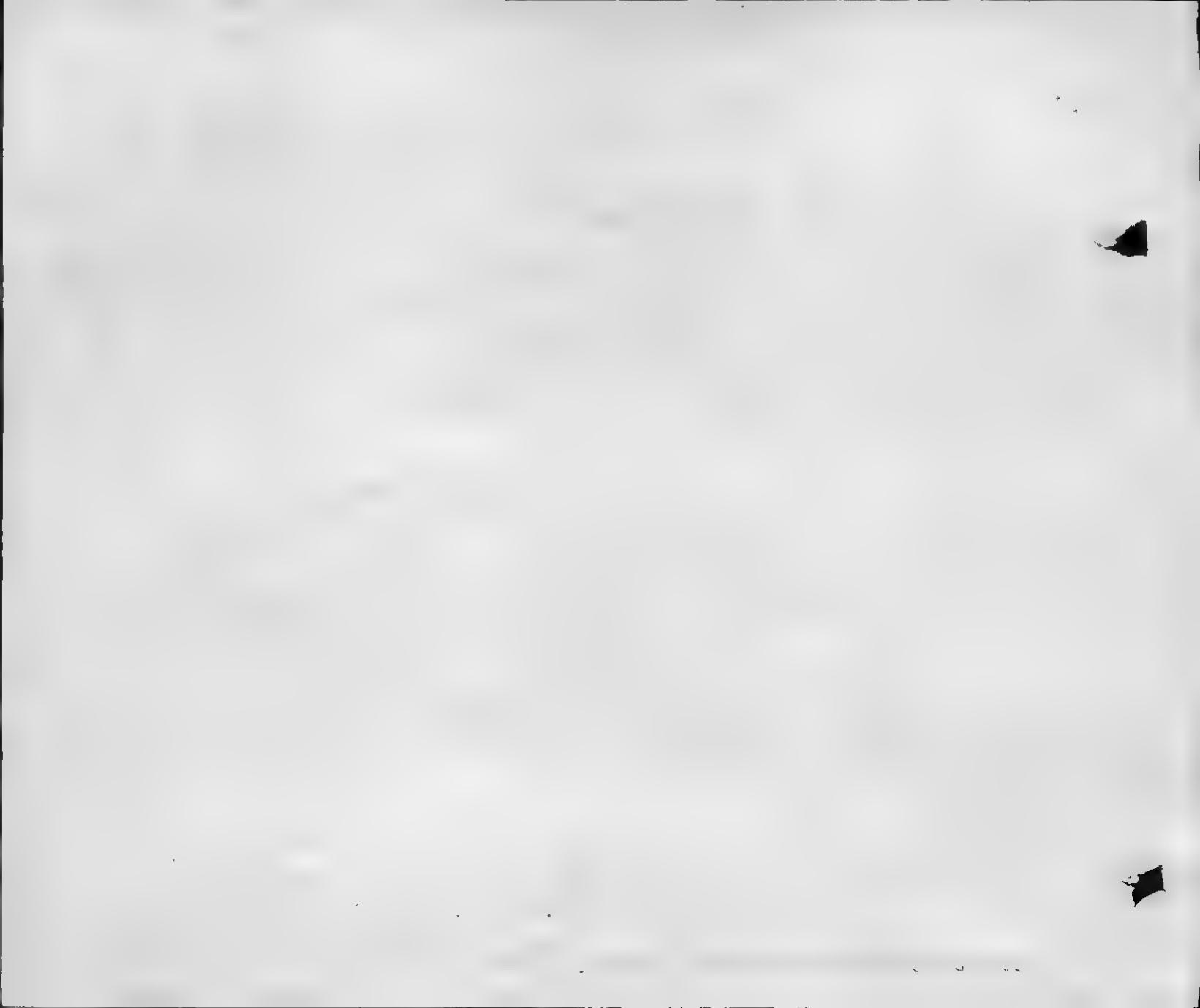
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08296

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Prince George Maryland		e. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George Gen. Hospital			
3. NAME OF DECEASED (Type or print) Leona C.		d. STREET ADDRESS 145 A Street	
First Middle		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M		f. DATE OF DEATH Month Day Year August 13 1887 73 yrs.	
6. COLOR OR RACE W		g. AGE (In years) IF UNDER 1 YEAR last birthday Months Days Hours Min.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		h. DATE OF BIRTH	
10b. KIND OF BUSINESS OR INDUSTRY Painter General construction			
11b. BIRTHPLACE (County & State, or foreign country) Connecticut			
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Cornelius Brown			
14. MOTHER'S MAIDEN NAME Millie Goodale			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No			
16. SOCIAL SECURITY NO.			
17. INFORMANT Mr. Eader Laurel Md Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema - Congestive Heart Failure			
-31 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Decubitus Ulcer - Severe			
DUE TO (c) C.V.A. - Possible Thrombosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-10, 1961, to 7-19, 1961, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Etienne</i>		22b. DATE SIGNED 7-27-61	
22c. PHYSICIAN'S NAME (Type) Dr. Etienne		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 29, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) Elmwood Cemetery Riverhead New York (State)	
24. FUNERAL DIRECTOR'S SIGNATURE DeWitt Donaldson, Laurel, Md.		25a. REC'D BY REGISTRAR JUL 31 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Tracy	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00297

8304

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E. Riverdale	
3. NAME OF DECEASED (Type or print) Howell		First S	Middle S
Last Brunson		4. DATE OF DEATH July 22 1961	Month Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 18 Jan 1898		9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo Engraver		10b. KIND OF BUSINESS OR INDUSTRY STAR NEWS PAPER	11. BIRTHPLACE (State or foreign country) DAISY GEORGIA
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME BENJAMIN BRUNSON	
14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes WAR II	
16. SOCIAL SECURITY NO. 257-10-3901		17. INFORMANT MRS. BELVA R. BRUNSON	Address SAMR A \$#2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 11-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>Multiple pulmonary emboli</i> <i>from a malignant disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
	20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from 7-11 1961 to 7-22 1961 , that (I) (we) last saw the deceased alive on 7/22/1961 , and that death occurred at 11:30 PM from the causes and on the date stated above.			
22a. SIGNATURE <i>George Hageage</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d ADDRESS Mt. Rainier, Md	22b. DATE SIGNED 7/23/61
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 28, 1961	23c. NAME OF CEMETERY OR CREMATORIAL PEMBROKE CEM.
24. FUNERAL DIRECTOR'S SIGNATURE Will Chambers Co. Riverdale, Md		ADDRESS	23d. LOCATION (City, town, or county) (State) PEMBROKE, GEORGIA
		25a. REC'D BY REGISTRAR DATE JUL 26 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Thomas



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8305

08298

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Prince George's

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF DECEASED
First Middle
(Type or print)4. SEX
Female Colored

5. COLOR OR RACE

6. MARRIED NEVER MARRIED WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chamber-Maid Hotel Raleigh Hotel

10b. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

John Buchanan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes, give rank and date of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 1, 1961, to July 7, 1961, that (I) (we) last saw the deceased alive on July 7, 1961, and that death occurred at 9:00 M, from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

23a. BURIAL, CREMATION, REMOVAL (Specify)
Shipping23b. DATE THEREOF
7/18/1961

23c. NAME OF CEMETERY OR CREMATORIAL

Lightner Funeral Home

23d. LOCATION (City, town or county)

(State)

Raleigh, North Carolina

24. FUNERAL DIRECTOR'S SIGNATURE

Alexander S. Kraus

ADDRESS

414 15th St. S. E.
Washington, D. C.

25e. REC'D BY REGISTRAR

JUL 10 '61

25b. REGISTRAR'S SIGNATURE

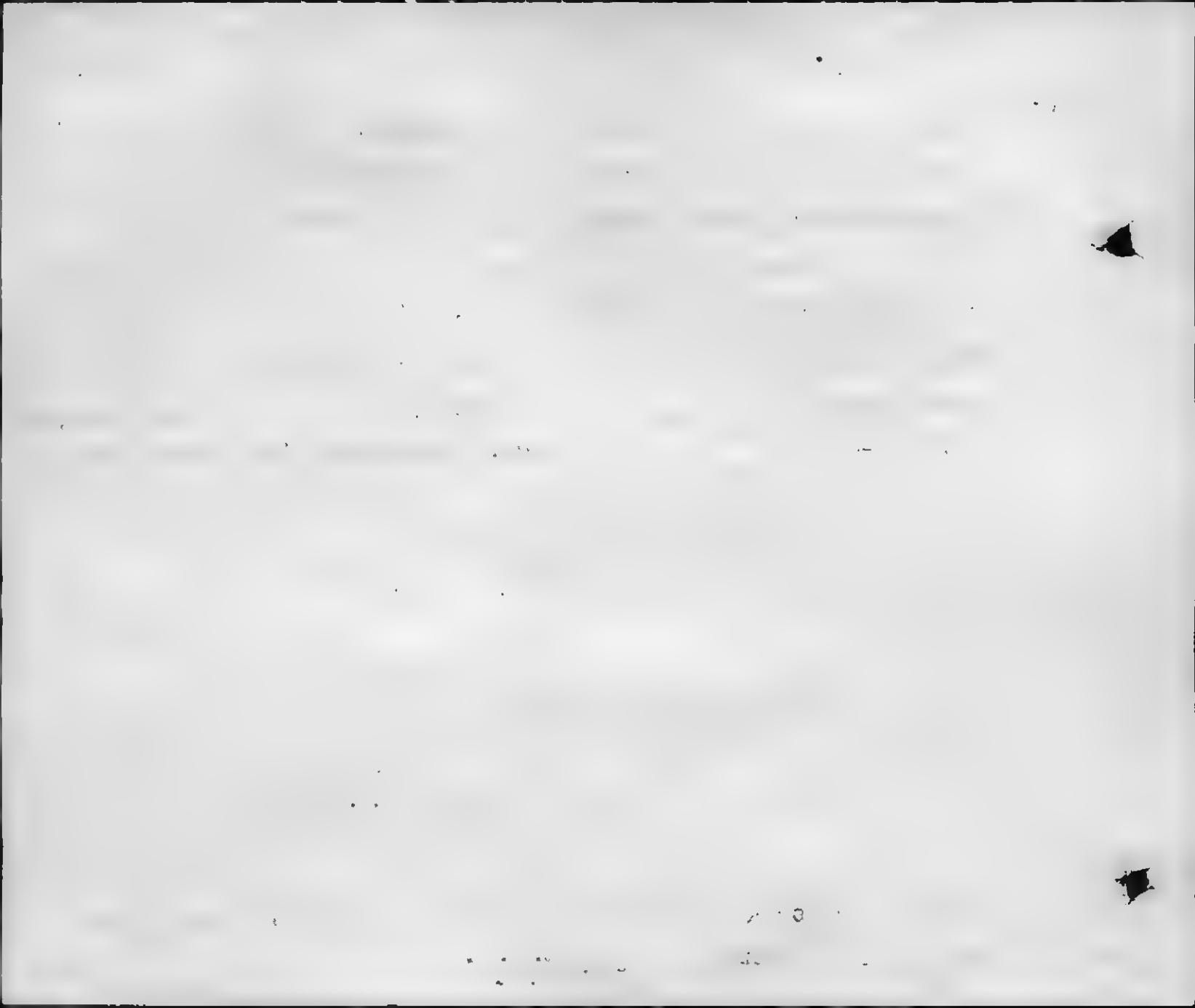
Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1
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VR A15 (4)
15M 9/60



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8306

CERTIFICATE OF DEATH

98299

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]

Cheverly

c. LENGTH OF STAY IN HOSPITAL

10 days

d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address]

Prince George's General Hospital

3. NAME OF DECEASED
(Type or print)

First Jessie

Middle Name M.

Campbell

4. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

8-22-96

10b. KIND OF BUSINESS OR INDUSTRY

Ownhome

9. AGE [In years. If under 1 year, list birthday] Months Days Hours Min.

61

4 yrs.

1 Month

0 Days

0 Hours

0 Min.

11. FATHER'S NAME

Housewife

12. CITIZEN OF WHAT COUNTRY?

David Cook

11. BIRTHPLACE, County & State or foreign country

Lonaconing, Md.

13. WAS DECEASED EVER IN U.S. ARMED FORCES? [Yes, no, or unknown] (If yes, give war or date of service)

No

14. MOTHER'S MAIDEN NAME

Jessie Mc Neil

Address

15. SOCIAL SECURITY NO. 16. INFORMANT

Hospital chart

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line, or (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Grenia

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.

(b)

DUE TO

(c)

Chronic pyelonephritis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

Observe of rt. kidney due to surgical removal

19. WAS AUTOPSY PERFORMED?

YES NO

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

Month, Day, Year

p.m.

19

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21. I certify that (I) (this hospital) attended the deceased from

September 18, 1961, to July 10, 1961,

that (I) (we) last saw the deceased alive on

July 10, 1961,

and that death occurred at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Hans Wodak

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

HANS WODAK

22d. ADDRESS

#9, E. Parkway Road, Greenbelt, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23c. NAME OF CEMETERY OR CREMATORIUM

Hill Crest Burial Park

23b. DATE THEREOF

July 13, 1961

23d. LOCATION (City, town or county)

Cumberland, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

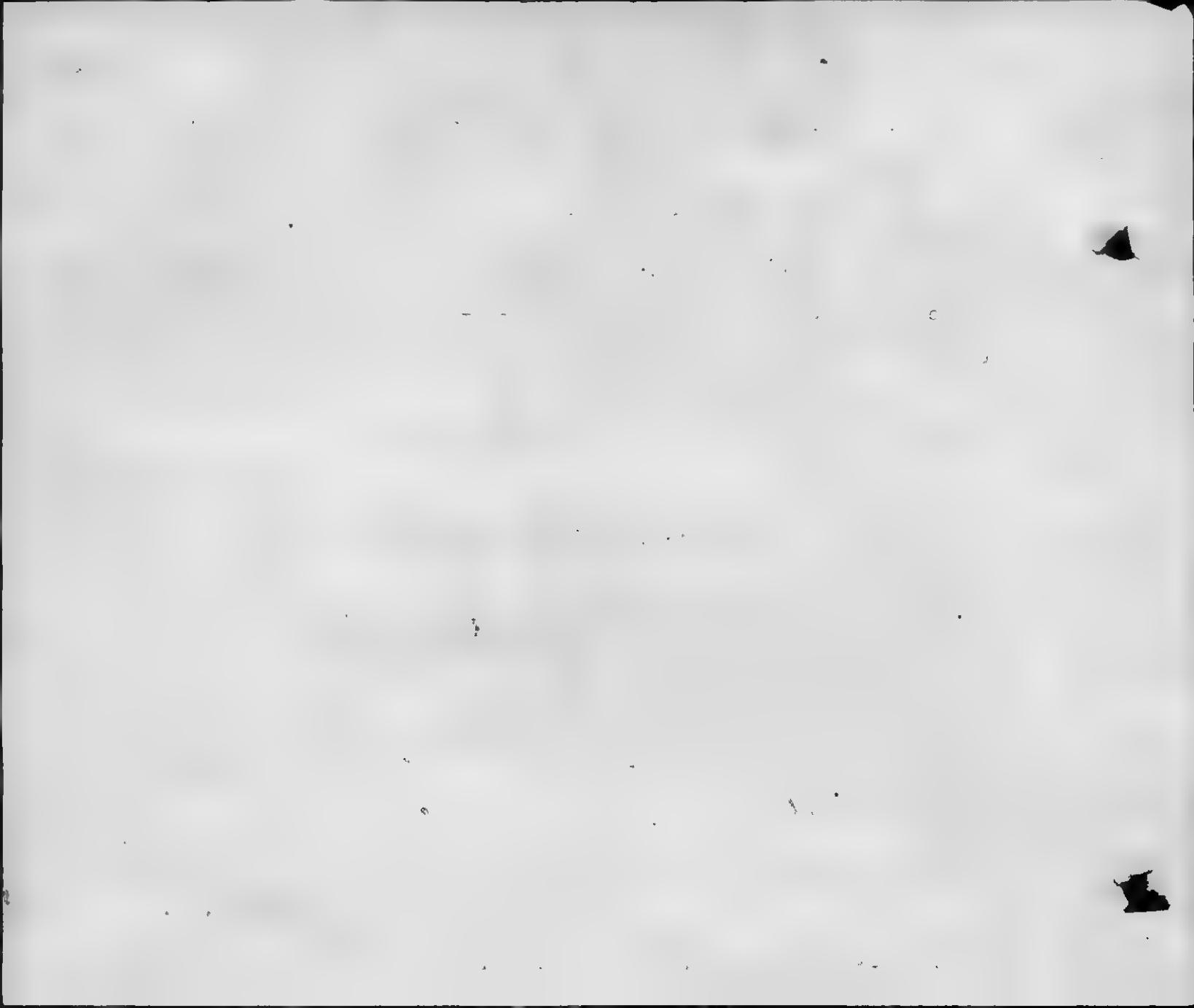
Scarpelli Funeral Home, Maryland

25a. REC'D. BY REGISTRAR

JUL 13 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thrus



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08300

8307 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Prince George's

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General

3. NAME OF
DECEASED
(Type or print)

First

Middle

Sadie

5. SEX

6. COLOR OR RACE

Female

White

WIDOWED

DIVORCED

Carpenter

4. DATE
OF
DEATH

7

Month

Day

Year

4

19

61

10a. USJAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

13. FATHER'S NAME

Biscar

15. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No No

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Congestive heart failure

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Cardiovascular renal disease

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e) 19. WAS A AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)
Burial

James I. Boyd

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial July 6, 1961 Ft Lincoln Cemetery

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

Colmar Manor, Md.

(State)

July 4, 1961

NOTICE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 4 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 7 days after death.

V.S. A15ME
5M 7/59

23. FUNERAL DIRECTOR

F. Gasch's Sons Hyattsville, Md.

ADDRESS

24a. REC'D BY REG STRR

JUL 10 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Frank



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8308

68301

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived if institut on: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>		b. COUNTY <i>Baltimore County</i>	
c. LENGTH OF STAY IN 1b <i>4802 - H St</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4802 - H St</i>		d. STREET ADDRESS <i>4802 - H St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William John Cissell</i>		4. DATE OF DEATH Month <i>July</i>	Day Year <i>20 1961</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>January 21, 1902</i>
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>	
10c. BIRTHPLACE (State or foreign country) <i>Wash DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Cissell</i>		14. MOTHER'S MAIDEN NAME <i>Theresa A. Taylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-09-0829</i>	
17. INFORMANT <i>Mrs. W. L. Lyle</i>		Address <i>4802 - H St, Capitol Heights</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i>		DUE TO <i>Carcinoma of Lung with metastasis</i>	
DUE TO <i></i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/18/60</i> to <i>7/20</i> , 1961, that (I) (we) last saw the deceased alive on <i>7/19</i> 1961, and that death occurred <i>5:30 PM</i> from the causes and on the date stated above		22b. DATE SIGNED <i>7/21/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>WM BRAININ</i>		22d. ADDRESS <i>6124 Central Ave, Capitol Heights</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>7/22/61</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>GRENWOOD CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>WASHINGTON D.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>WW Chambers Co.</i>		ADDRESS <i>517 11th St SE Wash D.C.</i>	
		25a. REC'D BY REGISTRAR <i>JUL 21 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles E. Krause</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8309

08302

ITEMS 13 & 14 FROM BIRTH CERTIFICATE 7/21/61 1W

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE	
Prince Georges MARYLAND		Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN lb 6 hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 6912 George Palmer Highway	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Clark
4. DATE OF DEATH	Month July	Day 19	Year 1961
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	18 July 1961
9. AGE (In years lost birthday) yrs		10. IF UNDER 1 YEAR Months 6 Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Clark		14. MOTHER'S MAIDEN NAME Norma Lee Kearns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cerebral anoxia</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Maternal Toxemia of Pregnancy</i>			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>18 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 18, 1961</i> , to <i>July 19, 1961</i> , that (I) (we) last saw the deceased alive on <i>July 18, 1961</i> , and that death occurred at <i>3:23 AM</i> from the causes and on the date stated above			
22a. SIGNATURE <i>W.H. Clements</i>		22b. DATE SIGNED <i>7/21/61</i>	
22c. PHYSICIAN'S NAME (Type) Dr. Clements, M.D.		22d. ADDRESS <i>6001-35th Ave, Hyattsville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE DEPOTED <i>7/21/61</i>	
		23c. NAME OF CEMETERY OR CREMATORIAL Washington National	
		23d. LOCATION (City, town, or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home, Washington D.C.		ADDRESS	
		25a. REC'D BY REGISTRAR <i>7/21/61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>	



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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

C8303

8310

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland		c. LENGTH OF STAY IN 1b 3 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase, Maryland		d. STREET ADDRESS 7212- Chestnut Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First CECILIA	Middle A.	Last CLARKE	4. DATE OF DEATH July 10th	Month July	Day 10th	Year 1961
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 17- 1875	9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Policewoman		11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Fitzpatrick			14. MOTHER'S MAIDEN NAME ? Demonet					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Frank J. Clarke Same as # 2.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>Retired</i> <i>Hyperfusion and arterosclerosis</i> <small>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</small> <small>DUE TO (b) DUE TO (c)</small> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
INTERVAL BETWEEN ONSET AND DEATH None.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 11, 1961, to July 10, 1961, that (I) (we) last saw the deceased alive on July 6, 1961, and that death occurred at 7:00 P.M. from the causes and on the date stated above								
22a. SIGNATURE <i>Thomas J. Kelly</i>		M.D. PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 10, 1961				
22c. PHYSICIAN'S NAME (Type) THOMAS J. KELLY		22d. ADDRESS 6480 N. H. Ave., Takoma Park, Md.						
23a. BURIAL, CREMAT. ON REMOVED (Specify) Burial		23b. DATE THEREOF July 13-61		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) Washington, DC (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Simmons Brothers</i>		1661- Good Hope Rd. SE Washington, DC		25a. REC'D BY REGISTRAR DATE JUL 13 '61		25b. REGISTRAR'S SIGNATURE <i>Clinton S. Thomas</i>		



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8311

08304

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood</i>	c. LENGTH OF STAY IN 1b <i>RURAL and give nearest town</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brentwood</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3900 Bunker Hill Road</i>		d. STREET ADDRESS <i>3900 Bunker Hill Road</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>ANNIE LUCRETIA CORNWELL</i>	First <i>A</i> Middle <i>L</i> Last <i>CORNWELL</i>	4. DATE OF DEATH <i>July 21 - 1961</i>	Month <i>July</i> Day <i>21</i> Year <i>1961</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUGUST 26 1868</i>
9. AGE (In years last birthday) <i>92 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>	11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>			
13. FATHER'S NAME <i>GEORGE POSEY</i>	14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>ESTELLE WHITE</i>	Address <i>BRENTWOOD MD</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
150/0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> (c) <i>Sensit</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>July 11 - 1961</i> , to <i>July 21 - 1961</i> , that (I) (we) last saw the deceased alive on <i>July 21 - 1961</i> , and that death occurred <i>around 11 PM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Thomas J. Kelly</i>	M. D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>July 23, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Thomas J Kelly</i>	22d. ADDRESS <i>6480 N. H. Ave., Takoma Park, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>7/25/61</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Manassas Cemetery</i>	23d. LOCATION (City, town or county) <i>Manassas Va</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Fischer son & H. Miller & Son</i>	ADDRESS <i>H. Miller & Son</i>	25a. REC'D BY REGISTRAR DATE <i>JUL 26 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8312 CERTIFICATE OF DEATH

Reg. Dist. No. 08306

1. PLACE OF DEATH a. COUNTY <i>Jurisdiction</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		c. LENGTH OF STAY IN 1b <i>Chesapeake</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District Heights</i>		d. STREET ADDRESS <i>7404 Lansdale St.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wardrobe, Chesapeake</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Deborah J. (Carmella) DeRicario</i>		First <i>D</i>	Middle <i>E</i>	Lost <i>July 25</i>	4. DATE OF DEATH <i>July 25</i>	Month <i>July</i>	Day <i>25</i>	Year <i>1961</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Feb 6, 1921</i>	9. AGE (In years last birthday) <i>40 yrs</i>	IF UNDER 1 YEAR <i>Months</i>	IF UNDER 24 HRS <i>Days</i>	Hours <i>00</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pittsburgh Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Antonio Patiarco</i>		14. MOTHER'S MAIDEN NAME <i>Carmella Vacuccio</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or date of service)</i>		17. INFORMANT <i>Charles A De Ricario</i>		Address <i>Same as De Ricario</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart attack and shock</i> DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of the Breast</i> DUE TO (c) <i>Metastatic Carcinoma of the Brain</i>									
INTERVAL BETWEEN ONSET AND DEATH <i>42 days</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>April 19 61</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>4440 Marlboro Rd.</i>		20f. (City or town) <i>Marlboro</i>		(County) <i>M.D.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>April 1961</i> to <i>July 25, 1961</i> , that I last saw the deceased alive on <i>July 25, 1961</i> , and that death occurred at <i>4440 Marlboro Rd.</i> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Deborah S. Stearns</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>Benjamin S. Pecon M.D.</i> DATE SIGNED									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-28-61</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) <i>Sykesville</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. H. Whiting, Jr. III</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JUL 31 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Stearns</i>			

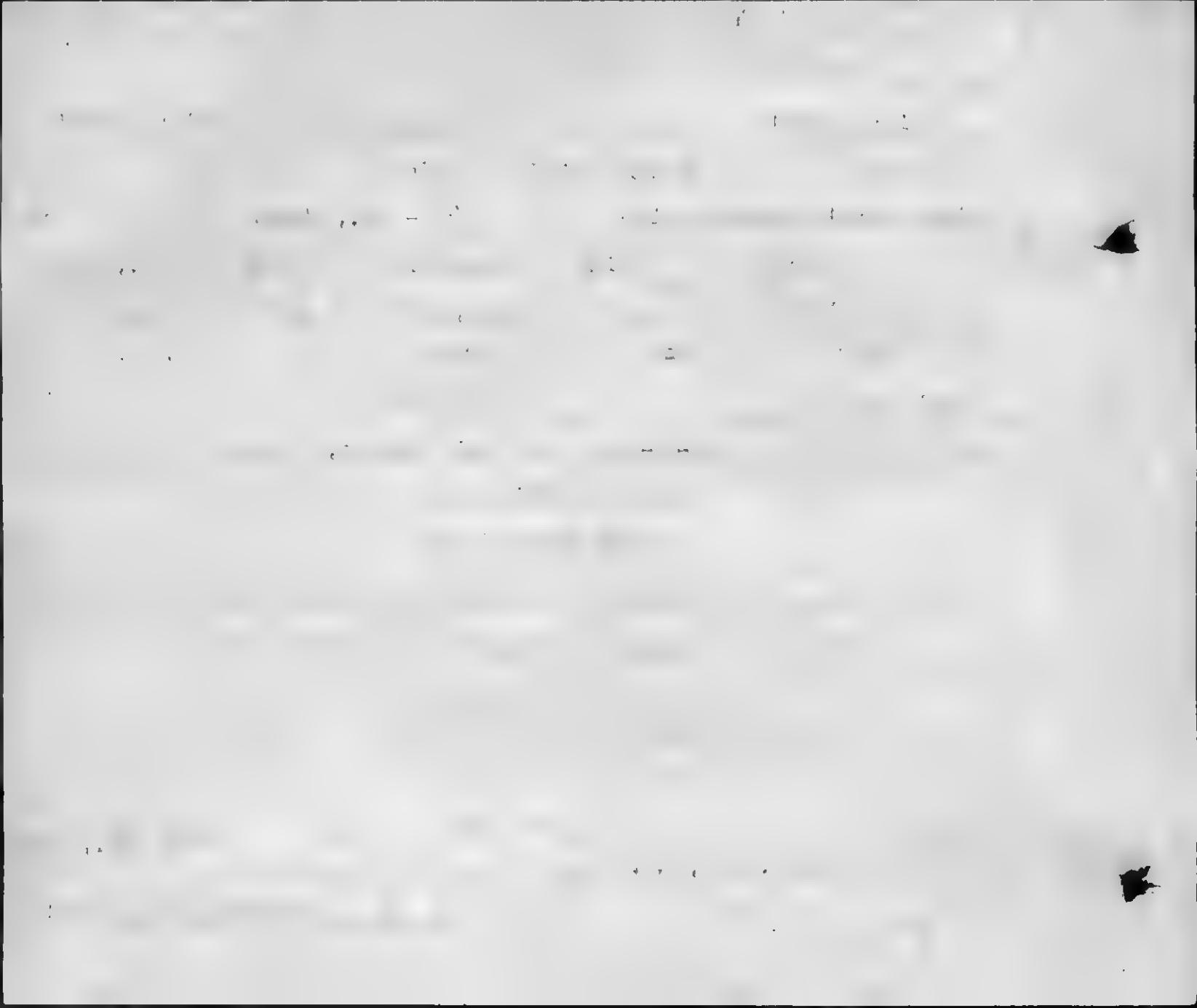


1
FOR STATE
HEALTH DEPT.



TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If max delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
831 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1B			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		
Prince George's			Cheverly			Dead on arrival			a. STATE		
MARYLAND									Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1B			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			b. COUNTY		
Cheverly			Dead on arrival			Bowie			Prince George's		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)											
Prince George's General Hospital						Bowie					
First Middle						Last			4. DATE OF DEATH		
3. NAME OF DECEDERED (Type or print)			Charles William			De Lauter			Month		
5. SEX			6. COLOR OR RACE			7. MARRIED			July		
Male			White			NEVER MARRIED			12th., 1961		
WIDOWED			DIVORCED			8. DATE OF BIRTH			IF UNDER 1 YEAR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			July 5, 1919			IF UNDER 24 HRS.		
Crane Operator			Grav ¹			11. BIRTHPLACE (State or foreign country)			Months Days Hours Min.		
13. FATHER'S NAME						Maryland					
Oscar DeLauter						14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			213-16-0937			Mrs Fannie DeLauter, same as # 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)											
42011 Coronary occlusion											
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)											
Coronary artery disease											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion, death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>JAMES I. BOYD</i>											
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED July 12th., 1961											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
22b. DATE THEREOF JULY 15, 1961											
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS FORT LINCOLN CEM.											
22d. LOCATION (City, town, or county) (State) BLADENSBURG, MARYLAND											
24a. REC'D BY REGISTRAR											
24b. REGISTRAR'S SIGNATURE <i>Walter S. Trahan</i>											
DATE JUL 14 '61											
VS. AISM SM 9/60											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8314

CERTIFICATE OF DEATH

C8303

1. PLACE OF DEATH
a. COUNTYPrince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General

NAME OF
DECEASED
(Type or print)

First

MARYLAND

c. LENGTH OF STAY IN lb

5. SEX

6. COLOR OR RACE

Male

7. MARRIED NEVER MARRIED

White

8. DATE OF BIRTH

C.

9. DATE
OF
DEATH

Seat Pleasant

d. STREET ADDRESS

611 64th Avenue

Last

Month

Dey

Year

July

25 19 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)
Court Librarian -Upper Marlboro, Md. Philadelphia, Pa.9. AGE (In years) IF UNDER 1 YEAR
Age (in years) Months Days Hours Min

51 yrs.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Viola Flaherty

Address

Mabel Helen Dempsey #2d above

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or date of service)

Yes WWII

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a).

1X SX

DUE TO

(b)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(c)

Bronchitis pneumonia, Adm.
Epidemic Cat. Left lung.INTERVAL BETWEEN
ONSET AND DEATH

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e.)

19. WAS AUTOPSY
PERFORMED?
YES NO 20e. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 7/27 1961, to 7/20 1961, that (I) (we) last
saw the deceased alive on 7/25 1961, and that death occurred at 3:10 PM, from the causes and on the date stated above.

22a. SIGNATURE

Max M. Herzberg

22c. PHYSICIAN'S
NAME (Type)

Max M. Herzberg, M.D.

22b. DATE
SIGNEDATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22d. ADDRESS

7016 Creig Street, Seat Pleasant, Md.

23e. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

23c. NAME OF CEMETERY

Burial 7/27/61

Saint Dennis

23d. LOCATION (City, town or county) (State)

Havorford Township, Delaware Co., Penna.

24 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

James T. Ryan Inc. 317 Pa Ave. S.E.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE JUL 28 '61

Arthur L. Krause

4 2 A

B C

D

E F

G H

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may
be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

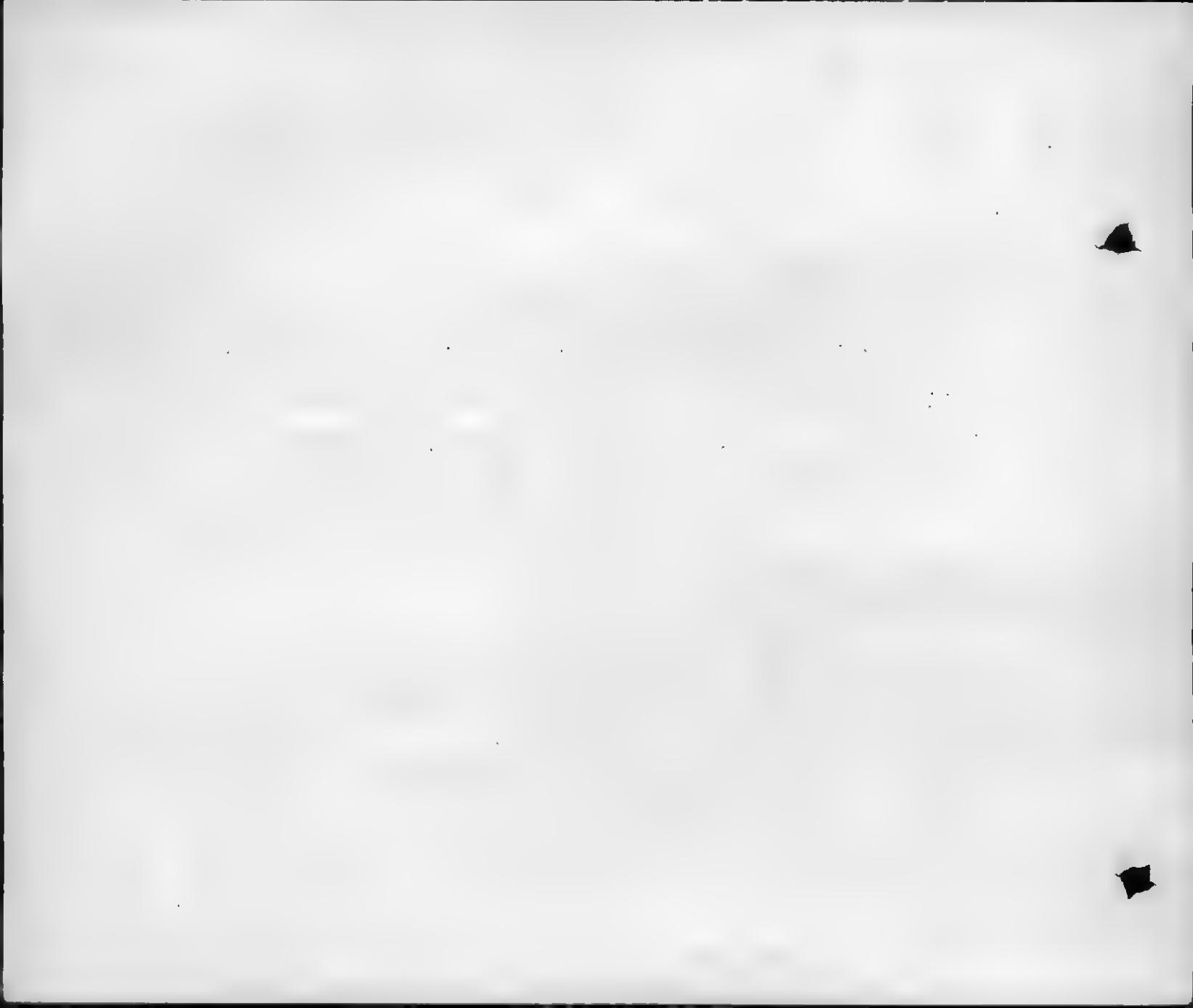
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08309

8315

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CHEVERLY</i>		c. LENGTH OF STAY IN 1b <i>D.O.A</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PRINCE GEORGE GENERAL HOSP, 9319 Lanham St,</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ralph</i>		First <i>JAMES</i>	Middle <i>Dough</i>
4. DATE OF DEATH <i>July 20 1961</i>		5. DATE OF BIRTH <i>12-5-1910</i>	Month Day Year
6. SEX <i>Male</i>		7. COLOR OR RACE <i>White</i>	8. DATE OF BIRTH MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MECHANIC</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AUTOMOBILE NACS HEAD, N.C.</i>	
10c. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>FRANKLIN PADDY LOTHIAN MD.</i>	
13. FATHER'S NAME <i>JOHN L. DOUGH</i>		14. MOTHER'S MAIDEN NAME <i>MINNIE BASNIGHT</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>231-05-9481</i>	
17. INFORMANT <i>FRANKLIN PADDY LOTHIAN MD.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic Heart Disease 6 mos	
		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 19 1954</i> to <i>July 20 1961</i> , that (I) (we) last saw the deceased alive on <i>July 19 1961</i> , and that death occurred at <i>1/4 M</i> , from the causes and on the date stated above		22a. SIGNATURE <i>Norman Donat Comeau</i>	
22b. DATE SIGNED <i>7/20/61</i>		22c. PHYSICIAN'S NAME (Type) <i>Norman Donat Comeau</i>	
22d. ADDRESS <i>3503 Perry St Mt Rainier Md</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	
23b. DATE THEREOF <i>7-22-1961</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>FT. LINCOLN CEM</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home Inc.</i>		23d. LOCATION (City, town, or county) (State) <i>Col MAR MANOR, MD.</i>	
ADDRESS <i>Mt. Rainier Md</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 24 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8315

CERTIFICATE OF DEATH

08310

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				d. STREET ADDRESS 2105 Banning Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First David	Middle L	Last Dowling	4. DATE OF DEATH	Month July	Day 21	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 25, 1955		9. AGE (In years lost birthday) 5 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME RUSSELL DOWLING		14. MOTHER'S MAIDEN NAME EVELYN DICKSON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO NONE		17. INFORMANT RUSSELL DOWLING		Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 749 X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO Post-operative pneumothorax, bilateral Surgery for correction of "funnel-chest"							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. Day p. m. Year 19 20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 6/1/61 , 19, to 7/21/61 , 19, that (I) (we) last saw the deceased alive on 6/4/61 , 19, and that death occurred at 52 Q , from the causes and on the date stated above 22a. SIGNATURE George William Ware M.D. ATTENDING PHYS <input checked="" type="checkbox"/> P.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED July 22, 61 22c. PHYSICIAN'S NAME (Type) Dr. George Ware, M.D. 22d. ADDRESS 1835 Eye St NW 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7-25-1961 23c. NAME OF CEMETERY OR Crematory Arlington National 23d. LOCATION (City, town, or county) (State) Arlington, Virginia 24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co ADDRESS Rivendale, Md. 25a. REC'D BY REGISTRAR DATE JUL 25 '61 25b. REGISTRAR'S SIGNATURE Chilton S. Kline							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8317

CERTIFICATE OF DEATH

8311

1. PLACE OF DEATH
a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN IB

24 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George General Hospital

3. NAME OF DECEASED
(Type or print)

First Mamie

Middle J

5. SEX
Female

6. COLOR OR RACE
White7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

10-27-87

Downing

4. DATE
OF
DEATH
July

Month Day

Year 1961

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Bureau of Engraving

11. KIND OF BUSINESS OR INDUSTRY

12. BIRTHPLACE (County & State, or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME Franklin Gage Tharpe

Joseph Deitz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give war dates of service)

no

Address

John Downing, Colmar Manor, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)173.0
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Perforatus

Adeno car n the rt ovary

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour a.m.

p.m.

49

White

Not White

at work

at work

21. I certify that (I) (this hospital) attended the deceased from... 6-12-1961 to 7-1-1961, that (I) (we) last saw the deceased alive on... 7-1-1961, and that death occurred at 11A.M. from the causes and on the date stated above.

22a. SIGNATURE

Deitz

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED
July 9, 196122c. PHYSICIAN'S
NAME (Type) Dr Aaron Deitz, M.D.23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial July 13, 1961 Evergreen Cemetery

ADDRESS

F. Gasch's Sons Hyattsville Md.

23d. LOCATION (City, town or county)

Bladensburg, Md.

(State)

25a REC'D BY REGISTRAR
DATE JUL 13 '6125b. REGISTRAR'S SIGNATURE
Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M		8318	08312																		
1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE Maryland				3. NAME OF DECEASED First Middle Clara B													
c. LENGTH OF STAY IN 1b RURAL and give nearest town) Cheverly				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
c. LENGTH OF STAY IN 1b RURAL and give nearest town) Cheverly				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 6005 39th Place				4. DATE OF DEATH Month Day Year July 30 61													
5. SEX Female				6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14, 1892				9. AGE (In years last birthday) 68 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. KIND OF BUSINESS OR INDUSTRY at Home		12. BIRTHPLACE (State or foreign country) Brooklyn, New York		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. KIND OF BUSINESS OR INDUSTRY at Home		12. BIRTHPLACE (State or foreign country) Brooklyn, New York				13. CITIZEN OF WHAT COUNTRY? U.S.A.		14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO NONE				17. INFORMANT Joan L. Griffith				Address Same as #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 33X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cerebral Thrombosis (c) DUE TO Cerebral Arteriosclerosis 2 mos. Generalized arteriosclerosis 1 yr.						INTERVAL BETWEEN ONSET AND DEATH 1 month	
19. MEDICAL CERTIFICATION				20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21. I certify that (I) (this hospital) attended the deceased from June 21, 1960 to July 30, 1961 , that (I) (we) last saw the deceased alive on July 30, 1961 , and that death occurred at 8:15 P.M. on the causes and on the date stated above.														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				22b. DATE SIGNED 7/30/61									
21. I certify that (I) (this hospital) attended the deceased from June 21, 1960 to July 30, 1961 , that (I) (we) last saw the deceased alive on July 30, 1961 , and that death occurred at 8:15 P.M. on the causes and on the date stated above.				22c. SIGNATURE Samuel J. N. Sugar				22d. ADDRESS 4637 EASTERN AVE., WASH 18 DC.													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 8-3-1961				23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Mem. Gardens				23d. LOCATION (City, town, or county) Fort Wayne, Indiana									
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Maryland				25a. ADDRESS W.W. Chambers Co. Riverdale, Maryland				25b. REC'D. BY REGISTRAR DATE AUG 2 '61				25b. REGISTRAR'S SIGNATURE ... 8 times									



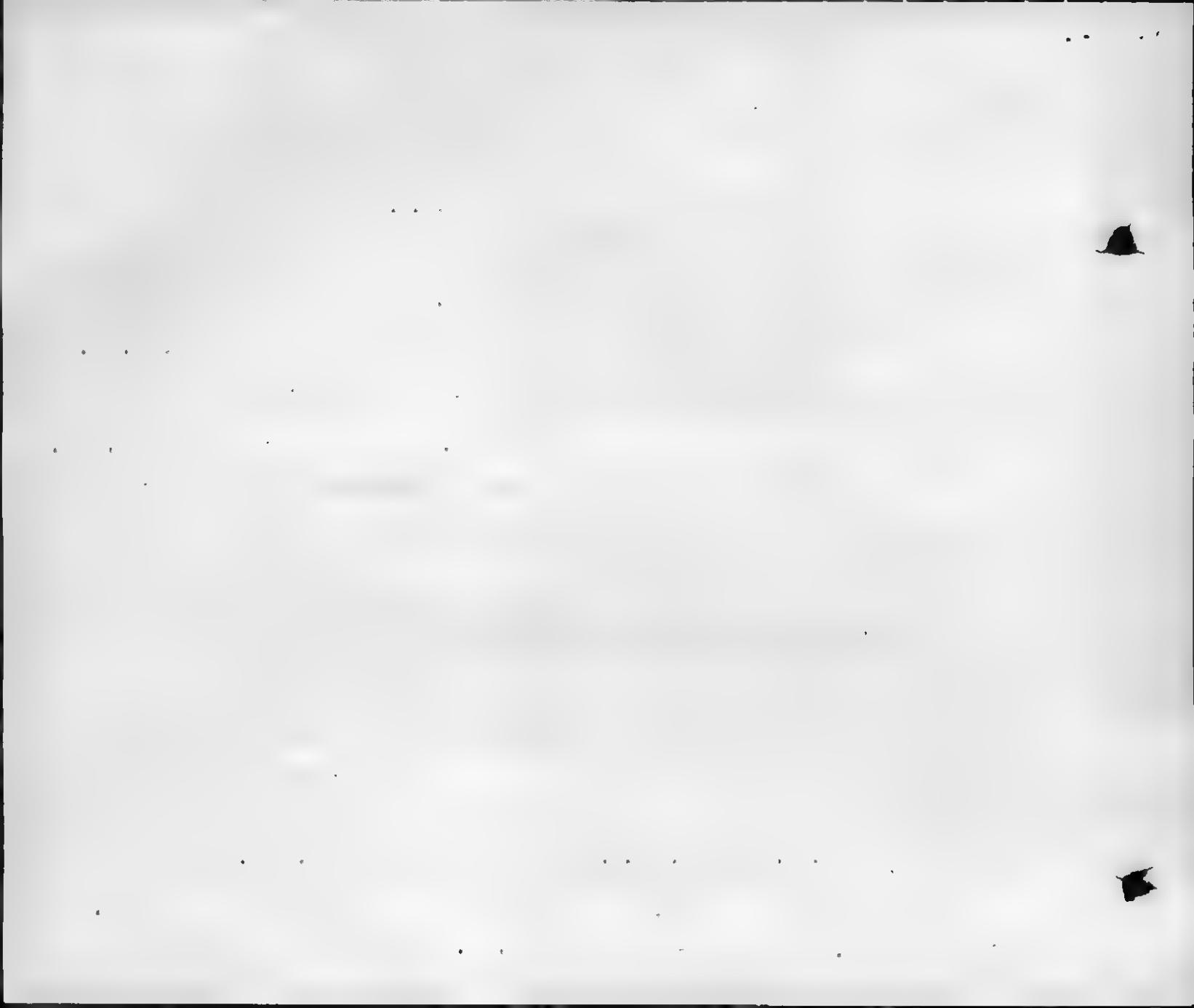
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
to
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8315		08313					
1. PLACE OF DEATH o. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 21 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Genral Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro					
3. NAME OF DECEASED (Type or print) Thomas		First Thomas	Middle Percy	Last Duvall	4. DATE OF DEATH July 29 1961		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5 Nov. 1888	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tobacco Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Frank Duvall				14. MOTHER'S MAIDEN NAME Elizabeth Van Ness			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Philip C. Duvall--Upper Marlboro, Md.		Address ---	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO AS CVR Disease (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes gangrene - left foot							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that (I) (this hospital) attended the deceased from Feb 1961 to 29 July 1961 , that (I) (we) last saw the deceased alive on 28 July 1961 , and that death occurred at 3,361 . All the causes and on the date stated above.							
22. SIGNATURE R. Sasscer		22b. DATE SIGNED 7/29/61					
22c. PHYSICIAN'S NAME (Type) R. Sasscer, M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 7/31/61		23c. NAME OF CEMETERY OR CREMATORIAL St. Thomas Cemetery		23d. LOCATION (City, town, or county) (State) Croom, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upr Marlboro, Md.		ADDRESS ---		25a. REC'D BY REGISTRAR DATE AUG 2 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8320

08314

CERTIFICATE OF DEATH

1
1. PLACE OF DEATH
a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Riverdale

c. LENGTH OF STAY IN 16

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Eugene Leland Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

INA

BERTHA

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

ECKER

8. DATE OF BIRTH

JUN 1-30-09

Oakland Mills Road

Last

Month

Dey

Year

July

16 1961

52 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Name

Tenn.

14. MOTHER'S MAIDEN NAME

13. FATHER'S NAME

George Loyd Davis

Judy Ann

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give year or dates of service)

No

Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

219-28-9853

Genebra Vascular Occlusion
Hypertension -

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

INTERVAL BETWEEN
ONSET AND DEATH11 hours
IndefiniteYES NO

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 7-16, 1961, to 7-16, 1961, that (I) (we) last saw the deceased alive on 7-16, 1961, and that death occurred at 20 from the causes and on the date stated above.

22e. SIGNATURE

D. R. Purdie
22c. PHYSICIAN'S NAME (Type)

D. R. Purdie, M. D.

ATTENDING PHYS.
M.D. MED. DIRECTOR
22d ADDRESS STAFF PHYS. 22e. DATE SIGNED
7-16-61

23a. BURIAL, CREMATION, ETC. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

4408 Queensbury Road, Riverdale, Maryland

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DeWitt Danielian, Laurel, Md.

ADDRESS

DATE

Clymer S. Krause



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8315

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Clinton

c. LENGTH OF STAY IN 1b

Transient

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Found in barn on Stoney Harbor Farm Rural

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

William

Henry

Farrell

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

MAR. 17, 1893

9. AGE (In years
last birthday)

68 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

UNEMPLOYED

10b. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

MARYLAND

13. FATHER'S NAME

WILLIAM H. FARRELL

14. MOTHER'S MAIDEN NAME

MARY WENK

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank, dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

JOHN F. FARRELL LAPLATA, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

4.11.11
DUE TO

(b)

DUE TO

(c)

CONGESTIVE HEART FAILURE

Hyper trophy and DILATATION, HEART

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

July 21, 1961

22e. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL 7-24-61

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

St Charles

ADDRESS

Indian Head, Md.

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR

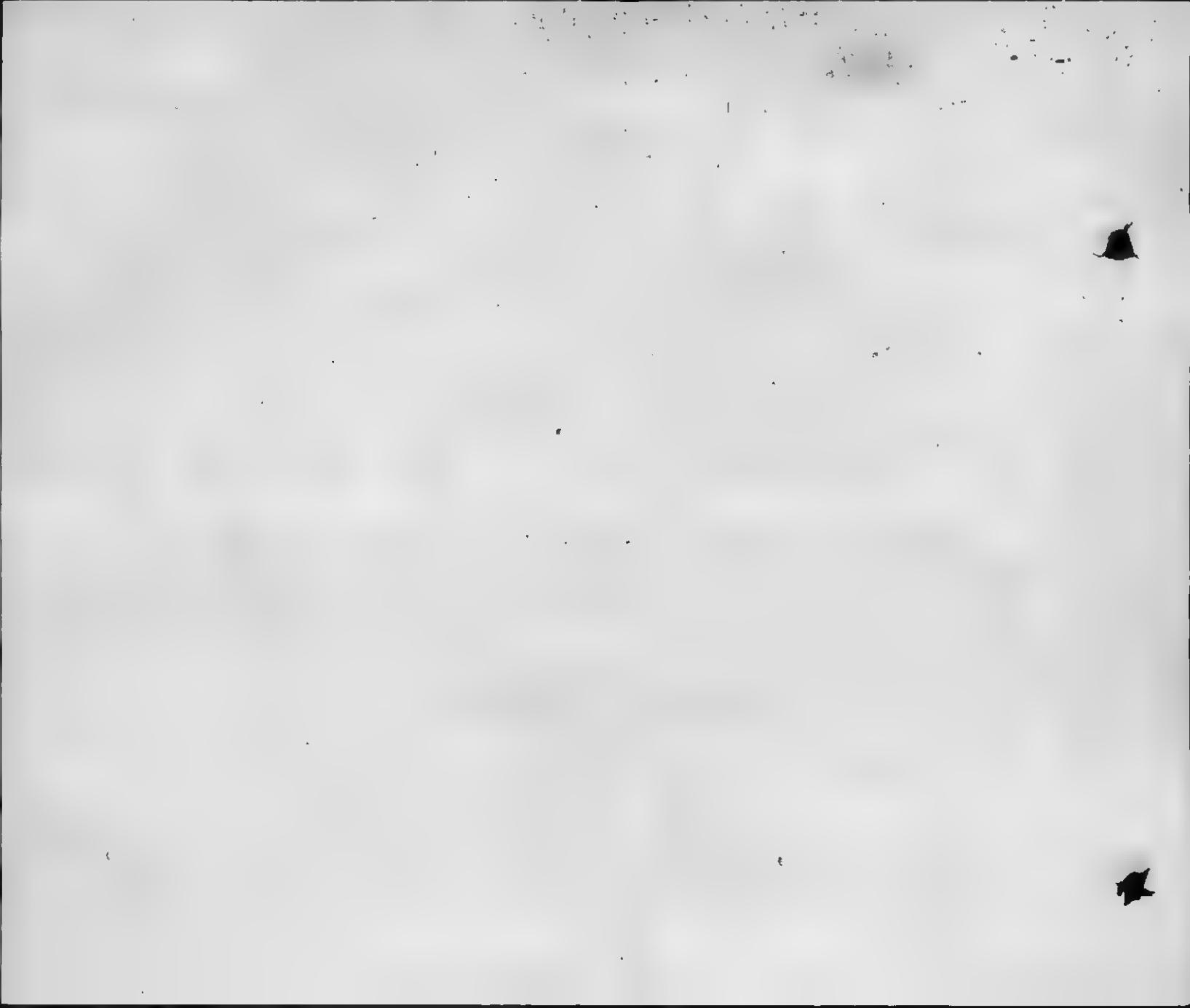
The Hunt Funeral Home, Waldorf, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATED JUL 26 '61

Arthur S. Traas



FOR STATE
HEALTH DEPT.

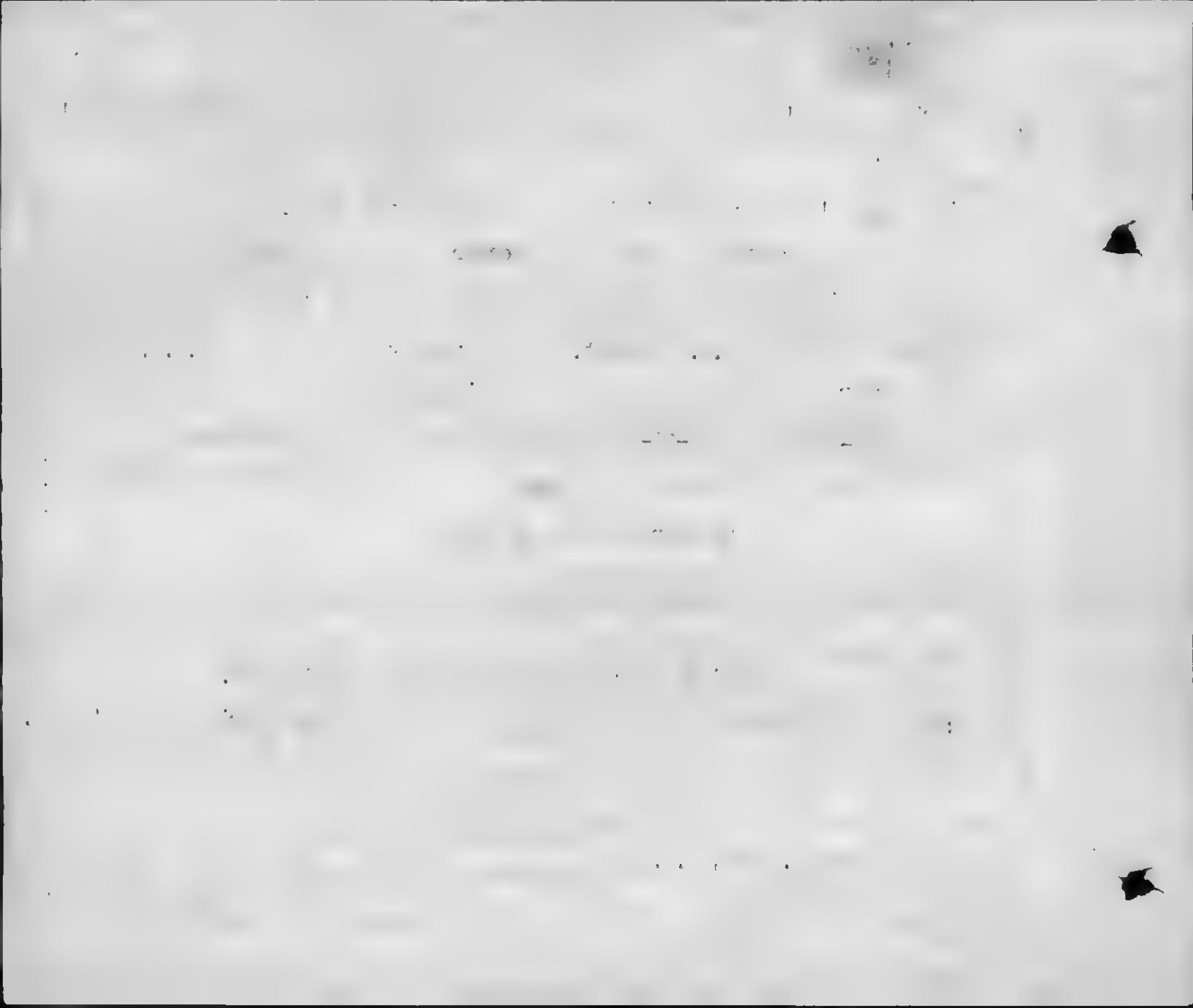
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8322

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C 316

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kentland		d. STREET ADDRESS 7202 Hawthorne Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		First Francis Middle Earl Last Fecher		4. DATE OF DEATH July 19 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				Month July Day 10 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 7/19/11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Dept.		9. AGE (in years last birthday) 49 yrs.		11. BIRTHPLACE (State or foreign country) Missouri	
13. FATHER'S NAME John Fecher		14. MOTHER'S MAIDEN NAME Lilly Perry		12. CITIZEN OF WHAT COUNTRY? U.S.A.		Address Same as #2	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give rank or dates of service) Yes 1935-1946		16. SOCIAL SECURITY NO. 489-32-3143		17. INFORMANT Thelma Fecher		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO (b) Gun shot wound in the head Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
976 X						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Went into bedroom of home and shot self in head.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour 5:05 p.m. Month, Day, Year 7/10/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Kentland (County) Prince George's (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/10/61	
ACTUAL SIGNATURE James I. Boyd, M.D.		EXAMINER'S NAME (Type) James I. Boyd, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1961		22c. NAME OF CEMETERY OR CREMATORIAL Campbridge Municipal		22d. LOCATION (City, town, or county) Campbridge, Iowa	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.		ADDRESS W.W. Chambers Co. Riverdale, Md.		24a. REC'D BY REGISTRAR Jul 14 '61		24b. REGISTRAR'S SIGNATURE John S. Thoms	
VS. A15ME SM 9/60							



FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8323

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08317

Items 10, 11 & 12 FILE

1. PLACE OF DEATH
a. COUNTY

Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

MARYLAND

c. LENGTH OF STAY IN 1b

Cheverly

d. NAME OF HOSPITAL OR INST TUT ON (if not in hospital, give street address)

Prince George's General

3. NAME OF
DECEASED
(Type or print)

First

Middle

Ghada

Last

Felds

4. DATE
OF
DEATH

Month

Day

Year

July

3

19 61

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

Female

Black

WIDOWED

DIVORCED

Oct. 12, 1928

9. AGE (In years) IF UNDER 1 YEAR
last birthday Months Days Hours

33 yrs.

Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if railroad)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

United States

13. FATHER'S NAME

Abraham Hill

14. MOTHER'S MAIDEN NAME

Fannie Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give war or date of service)

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

(b)

DUE TO

(c)

acute pulmonary edema
Bronchitis sinusitis laryngitis

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

7/7/61

22c. NAME OF CEMETERY OR CREMATORIUM

Arlington National Cemetery

22d. LOCATION (City, town, or county)

Arlington, Va.

(State)

23. FUNERAL DIRECTOR

ADDRESS

Robert J. Snodderly Rockville, Md.

24a. REC'D BY REGISTRAR

JUL 13 '61

24b. REGISTRAR'S SIGNATURE

Charles S. Krause

1870

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8324

CERTIFICATE OF DEATH

08318

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY

Pr. Geo.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Oxon Hill

c. LENGTH OF STAY IN 1b

10 years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

6501-Circle Dr. SE

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

July 20 1961

5. SEX

6. COLOR OR RACE

Male

White

10a. JEWISH OCCUPATION (Give kind of work done during most of working life even if retired)

O.M.C.

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

MARCH 27 1917

9. AGE (In years last birthday)

44 yrs.

10. IF UNDER 1 YEAR

Months Days Hours Min.

11. IF UNDER 24 HRS

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

NEBRASKA

USA

13. FATHER'S NAME

Fred Filter

14. MOTHER'S MAIDEN NAME

Martha Brummond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Lorraine E. Filter - Same as #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

CORONARY THROMBOSIS

INTERVAL BETWEEN
ONSET AND DEATH

20

41DX
DUE TOConditions, if any, which
gave rise to immediate
cause (a), stating the under
lying cause last

(b)

RHEUMATIC HEART DISEASE

25 years

(c)

AORTIC + MITRAL INSUFFICIENCY.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 2-23 1961, to 7-20 1961, that (I) (we) last saw the deceased alive on 7-17 1961, and that death occurred at 9 AM, from the causes and on the date stated above.

22a. SIGNATURE

Miguel A. Huici

M.D.

ATTENDING PHYS

MED DIRECTOR

STAFF PHYS

22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

MIGUEL A. HUICI

22d. ADDRESS

523 Y LIVINGSTON Rd. S.E.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Summons Bros 1661 1/2 Hope Rd S.E.

25a. REC'D BY REGISTRAR

DATE JUL 24 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas



1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8325

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

88319

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cheverly

c. LENGTH OF STAY IN TB

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
DECEASED
(Type or print)

First
Michael

Middle
Aloysius

Last
Foley

4. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Plasterer

10b. KIND OF BUSINESS OR INDUSTRY

Building

8. DATE OF BIRTH

January 25, 1896

9. AGE (in years
less birthday)
yrs.

80

10. IF UNDER 1 YEAR
Months Dey

Hours Min.

11. IF UNDER 24 HRS.

Address

11. BIRTHPLACE (State or foreign country)

District of Columbia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Patrick Foley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or details of service)

Yes.

WW 1

16. SOCIAL SECURITY NO.

578-14-4523

17. INFORMANT

Michael E. Foley, 8310 Stanwood Street
Carrollton, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4201
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Coronary occlusion

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
MATERIAL

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23. FUNERAL DIRECTOR

Dimitriy Iordanov

Funeral Home

Ave NW

24a. DATE THEREOF

7-18-61

22b. DATE THEREOF

7-18-61

22c. NAME OF CEMETERY OR CREMATORIUM

Arlington Nat'l

Cemetery

22d. LOCATION (City, town, or county)

Arlington Na.

(State)

24b. REC'D BY REGISTRAR

Matthew S. Krause

24b. REGISTRAR'S SIGNATURE

Matthew S. Krause

12

FOR STATE
HEALTH DEPT.

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08320

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Berwyn Heights

c. LENGTH OF STAY IN 16

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

8402 - 57th., Avenue

Middle

3. NAME OF
DECEASED
(Type or print)

Bertha

Mac

Frey

4. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

March 11, 1880

9. AGE (In years last birthday)

81

yrs.

Months

Days

Hours

Min.

e. IS RESIDENCE
ON A FARM?
YES NO

13. FATHER'S NAME

XXXXXX Romandos Fogal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mr. Kenneth H. Frey, same as # 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

ASPHYXIA

97 4X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

DUE TO

(b)

DUE TO

(c)

HANGING

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Hanged self from door in bed room

20c. TIME OF INJURY Month, Day, Year

Hour e.m.

4:30XX 7/6/1961

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Room, hall, factory, street, office bldg., etc.)

Home

Berwyn Heights

19. WAS AUTOPSY
PERFORMED?

YES NO

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

July 6th., 1961

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country) (State)

Coopersburg, Penns.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial July 10, 1961, St Pauls Cemetery

23. FUNERAL DIRECTOR

W.W. Chambers Co Riverdale, Md

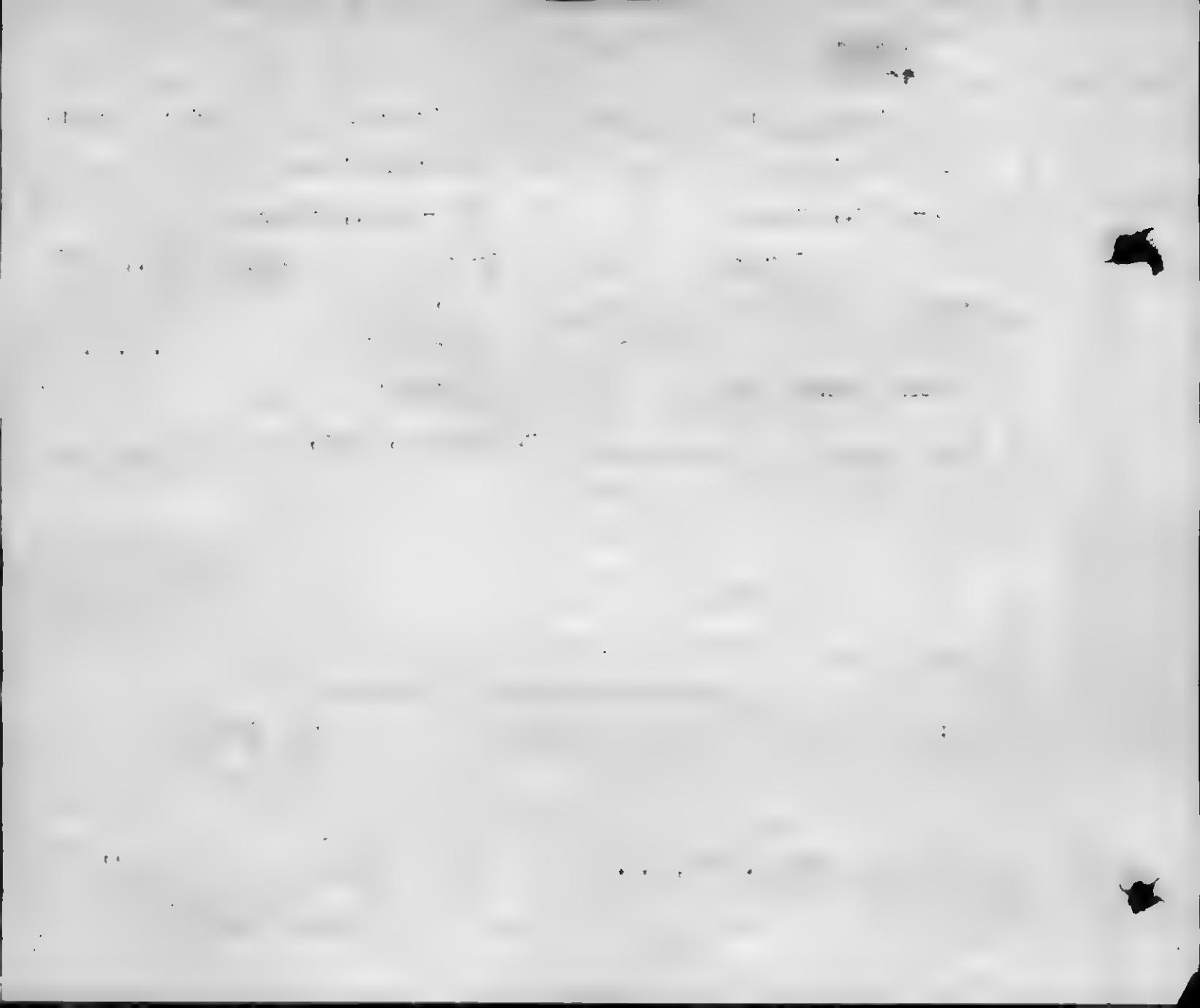
ADDRESS

24a. REC'D. BY REGISTRAR JUL 12 1961

DATE

24b. REGISTRAR'S SIGNATURE

Lorraine L. Mann



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08321

8327

M

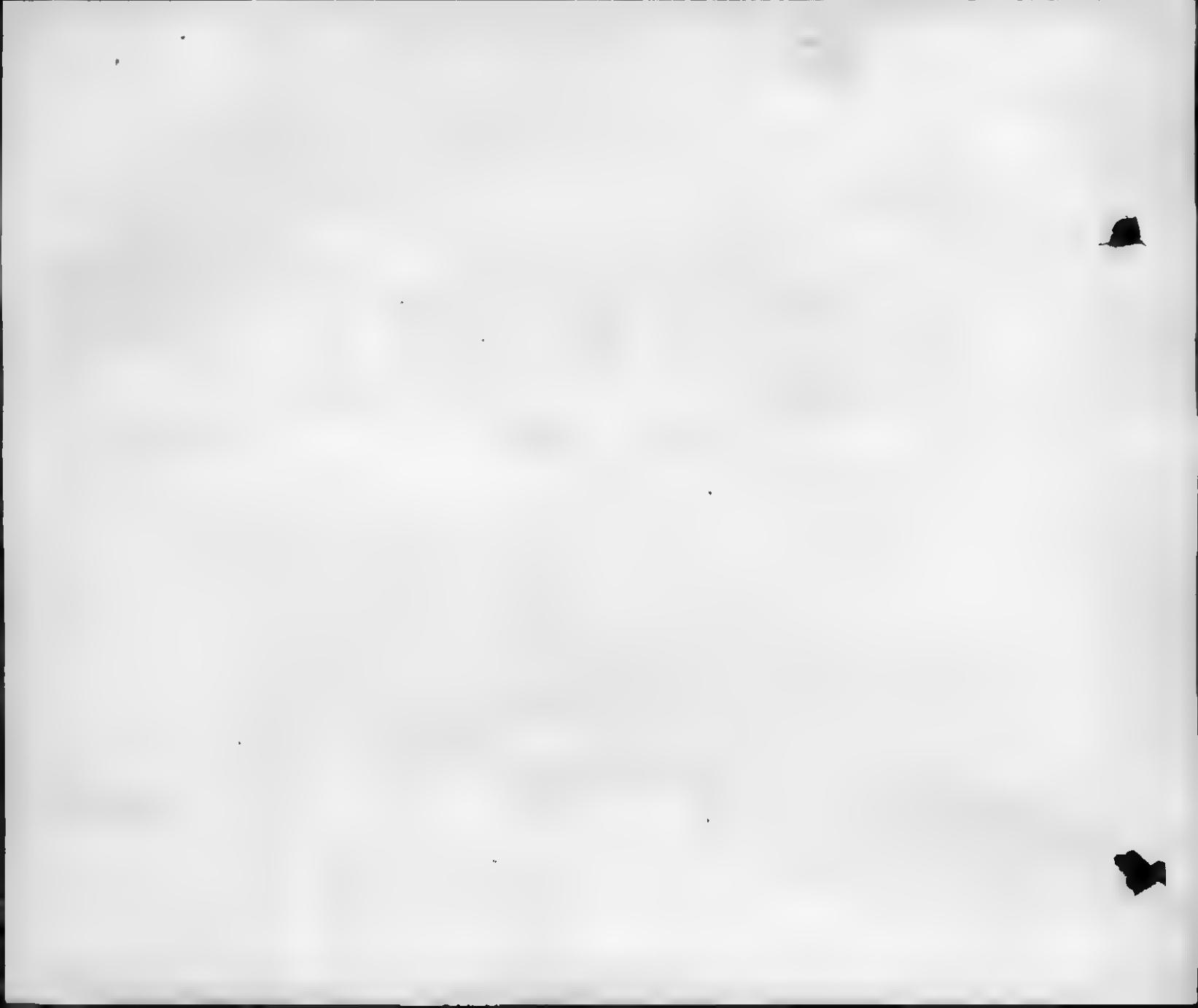
三

I

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY PRINCE GEORGES			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND					
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL, MD				d STREET ADDRESS 4775 HURON AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) STEPHEN		First	Middle	Last	GERMANA	DATE OF DEATH	Month JULY	Day 3	Year 19 61
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 OCTOBER 1959	9. AGE (In years lost birthday) 1 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? UNITED STATES			
13. FATHER'S NAME RICHARD W GERMANA		14. MOTHER'S MAIDEN NAME ELENA M CUCCURULLO		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT FATHER		SAME AS ITEM #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Respiratory Obstruction				INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO		(b) Tumor of Mediastinum							
(c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)			
21 I certify that (I) (this hospital) attended the deceased from 30 June 1961 to 3 July 1961 , that (I) (I) last saw the deceased alive on 3 July 1961 , and that death occurred at 11:15 AM from the causes and on the date stated above									
22a SIGNATURE Philip A. Cox, Col. USAF		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22b DATE SIGNED 3 July 61			
22c PHYSICIAN'S NAME (Type) PHILIP A COX, Colonel USAF MC		22d. ADDRESS USAF HOSP, ANDREWS AFB, MD							
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 6 July 1961		23c NAME OF CEMETERY OR CREMATORIAL ARLINGTON NATIONAL		23d. LOCATION (City, town, or county) ARLINGTON Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Cesaldi Funeral Home Inc. 816 H St. NE		ADDRESS DC 2		25a REC'D BY REGISTRAR JUL 6 '61		25b REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MEDICAL CERTIFICATION

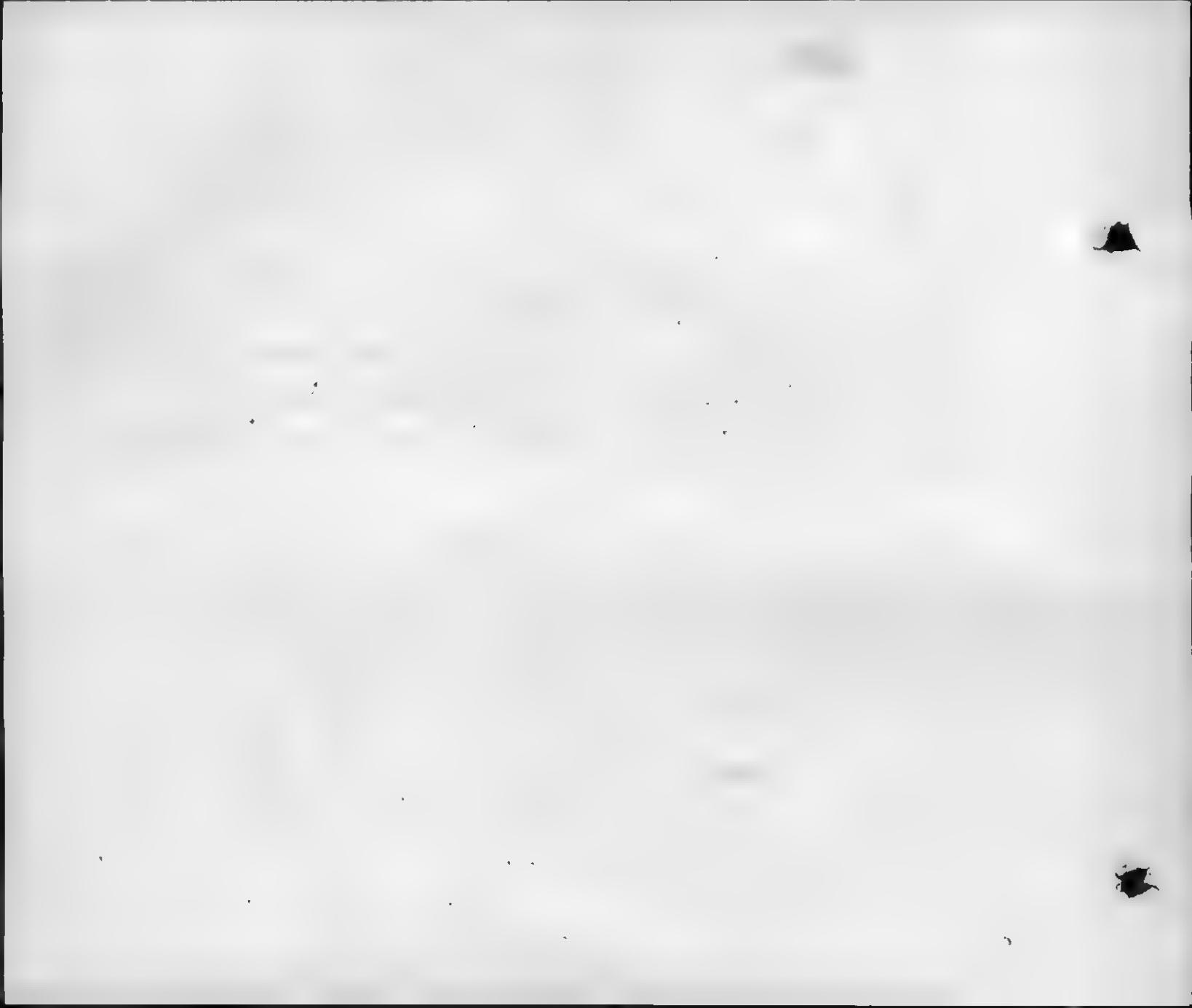
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8328

CERTIFICATE OF DEATH

08322

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Marshall	Middle WAYLAND	Last Gilbert
4. DATE OF DEATH	Month July	Day 31	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH DEC 30, 1885
9. AGE (in years lost birthday) 75 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor, Retired	11. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? 11. BIRTHPLACE (State or foreign country) N.CAROLINA U.S.A.	13. FATHER'S NAME JAMES M. GILBERT
14. MOTHER'S MAIDEN NAME HENRIETTA ROWLAND	15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	16. SOCIAL SECURITY NO. 246-07-5887	17. INFORMANT ALICE SCHIATTAREGGIA
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 49 IX DUE TO Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)	19. INTERVAL BETWEEN ONSET AND DEATH 2 DAYS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? BROCHIAL ASTHMA YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on and that death occurred at , from the causes and on the date stated above.			
22c. PHYSICIAN'S NAME (Type) C. James Duke, M.D.	M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 8/1/61	
23a. BURIAL, CREMATION OR REMOVAL (Specify) 23b. DATE THEREOF AUG 3, 1961 23c. NAME OF CEMETERY OR CREMATORIUM FORT LINCOLN CEM.			
24. FUNERAL DIRECTOR'S SIGNATURE Will Chambers Co. Riverdale, Maryland		ADDRESS	25a. REC'D BY REGISTRAR DATE AUG 4 '61
			25b. REGISTRAR'S SIGNATURE Wm. S. Evans



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 24 hours after death.

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8329

8323

CERTIFICATE OF DEATH

1. PLACE OF DEATH

e. COUNTY

Prince Georges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural - Glenn Dale

MARYLAND

c. LENGTH OF STAY IN 1b

1 mo., 5 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Glenn Dale Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

S. Goodman

5. SEX

6. COLOR OR RACE

Female white

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

April 17, 1897

9. Lest

4. DATE
OF
DEATH

Month

Day

Year

July

1

1961

9. AGE (In years
last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

64 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Accountant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

General Service Adm. Pittsburgh, Pa.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William J. Miller

14. MOTHER'S MAIDEN NAME

Martha Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give war or date of service.)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address 1701 16th St.
N.W. Wash.D.C.

Unknown (Person) Edna M. Murray,

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

157X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Carcinoma of the Pancreas with metastases to liver 1 yr. 5 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT. ON GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?

YES NO

Cholecysto-enterostomy and gastro-jejunostomy, June, 1960

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that (I) (this hospital) attended the deceased from May 26, 1961, to July 1, 1961, that (I) (we) last
saw the deceased alive on July 1, 1961, and that death occurred at 10:05 PM, from the causes and on the date stated above.

22a. SIGNATURE

Moe Weiss

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

July 1, 1961

22c. PHYSICIAN'S
NAME (Type)

Moe Weiss, M.D.

22d. ADDRESS

Glenn Dale Hospital, Glenn Dale, Md.

23a. FUNERAL CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREATORIAL

23d. LOCATION (City, town or county)

(State)

July 5, 1961 Arlington Nat'l Cemetery Fort Myer, Va

24. FUNERAL DIRECTOR'S SIGNATURE

Jaspar Charles Lane 175 Penn Ave. N.W. Washington, D.C. 20535

25a. ADDRESS

25b. REGISTRAR'S SIGNATURE

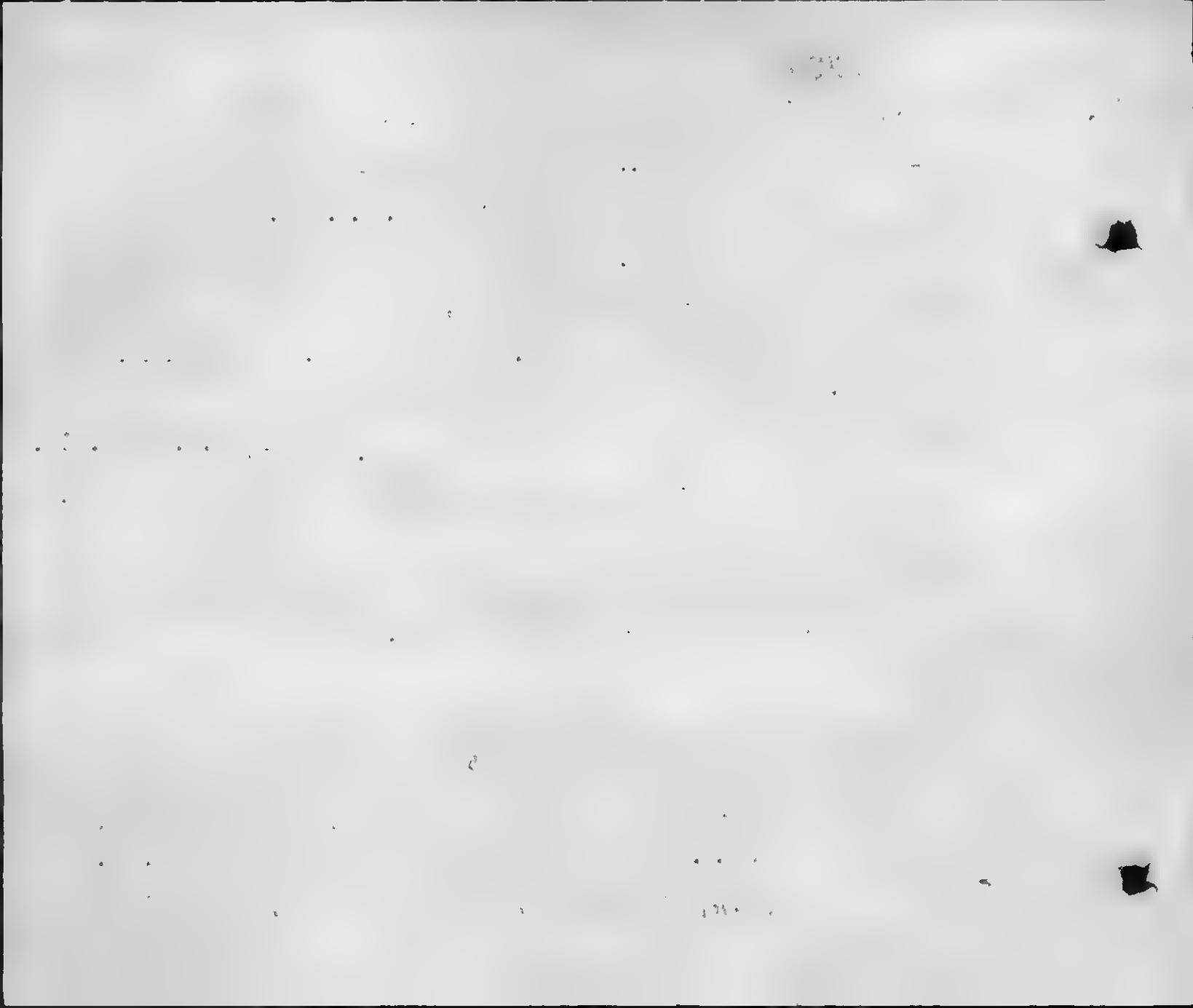
JUL 5 '61

25b. REGISTRAR'S SIGNATURE

Clinton S. Times

JUL 5 '61

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8330

CERTIFICATE OF DEATH

98324

1. PLACE OF DEATH

a. COUNTY

Prince Georges

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

26 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince Georges General Hospital

3. NAME OF
DECEASED
(Type or print)

Bernard

C

First Middle

4. SEX

Male

White

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

10a. JSLAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Icon. Service Ad.

11. BIRTHPLACE (County & State, or foreign country)

Wash. D.C.

13. FATHER'S NAME

Bernard

Goodwin

Laura Mills

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, where or date of service)

CS

W.W.I

16. SOCIAL SECURITY NO.

57-378-4737

17. INFORMANT

Hospital Records

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMED ATC CAUSE (a)

Uremia

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

HYPERTENSIVE RENAL NEPHRO SCEROSIS

INTERVAL BETWEEN
ONSET AND DEATH

26 day

10 yrs.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCR BE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 10, 1961, to July 11, 1961, that (I) (we) last saw the deceased alive on July 10, 1961, and that death occurred on July 10, 1961, from the causes and on the date stated above.

22a. SIGNATURE

Albert Roth

M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Dr. Albert Roth, M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE

Hanlon F.H. 3631 Balaen H.W.

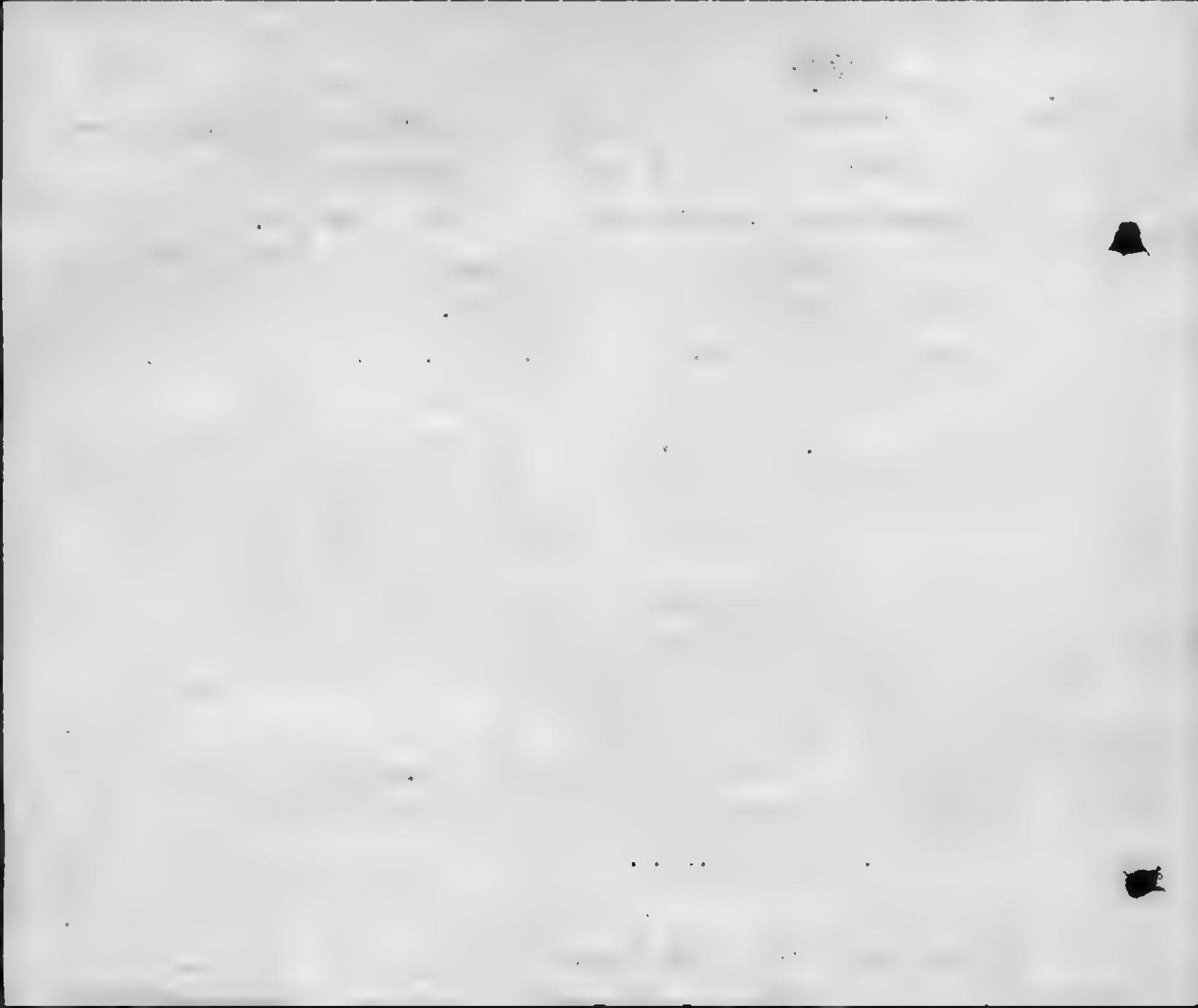
ADDRESS

25b. REC'D BY REGISTRAR

JUL 18 1961

25b. REGISTRAR'S SIGNATURE

Arthur S. Moore



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

M

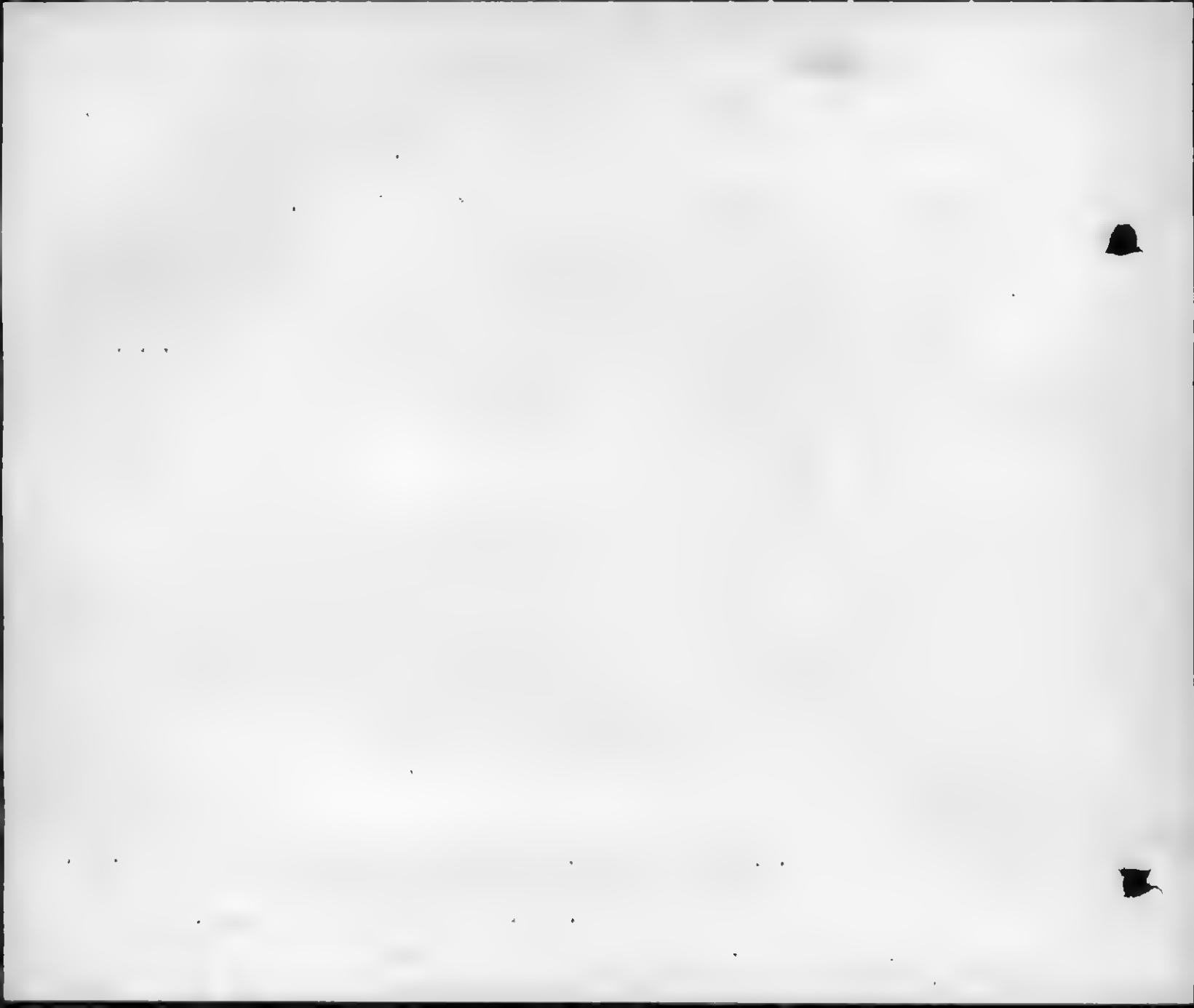
**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

8331

CERTIFICATE OF DEATH

08325

1. PLACE OF DEATH o COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Maryland b COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Hill			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 8921 Old Fort Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Baby	Middle Boy	Last Gordon	4. DATE OF DEATH July 14	Month Year 1961		
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 July 1961		9. AGE (in years last birthday) yrs. 14	IF UNDER 1 YEAR Months 14	IF UNDER 24 HRS Hours Min. 0
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Jackson		14. MOTHER'S MAIDEN NAME Grace Gordon					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tetralogy of Fallot 75410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Congenital Heart Disease from birth DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that death occurred at 7:05 AM , from the causes and on the date stated above							
22a. SIGNATURE Thomas A. Christensen		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/13/61			
22c. PHYSICIAN'S NAME (Type) Thomas A. Christensen, M.D.		22d. ADDRESS 6905 Baltimore Ave., College Park, Md.					
23a. BURIAL CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/22/61		23c. NAME OF CEMETERY OR CREMATORIAL Prince Geo. Gen. Hospital		23d. LOCATION (City, town, or county) Cheverly, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Penry, Jr., Administrator		ADDRESS		25a. REC'D BY REGISTRAR JUL 24 '61		25b. REGISTRAR'S SIGNATURE C. Slagle & Hayes	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08326

1. PLACE OF DEATH

a. COUNTY

Prince George's

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

DOA

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

e. NAME OF
DECEASED
(Type or print)

First

Middle

Luther

Hedrick

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

Luther Hedrick Griffin, Jr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Asphyxia

129.8

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last

(b) Drowning

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

INTERVAL BETWEEN
ONSET AND DEATH

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Fell off of pier into pond.

19. WAS AUTOPSY
PERFORMED?

YES NO

20c. TIME OF INJURY

Month, Day, Year

Hour 7:30 p.m.

7/7/61

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Farm

20f. (City or town)

(County)

(State)

Woodmore Prince George's Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

22e. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

7/11/61

Ft. Lincoln Cemetery

Bladensburg

Md.

23. FUNERAL DIRECTOR

Ritchie Bros. Fun'l Home-Upper Marlboro, Md.

ADDRESS

JUL 14 '61

REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in event within 72 hours after death.

14. MEDICAL CERTIFICATION

SIGNATURE

James I. Boyd, M. D.

EXAMINER'S
NAME (Type)

CHIEF MEDICAL EXAMINER

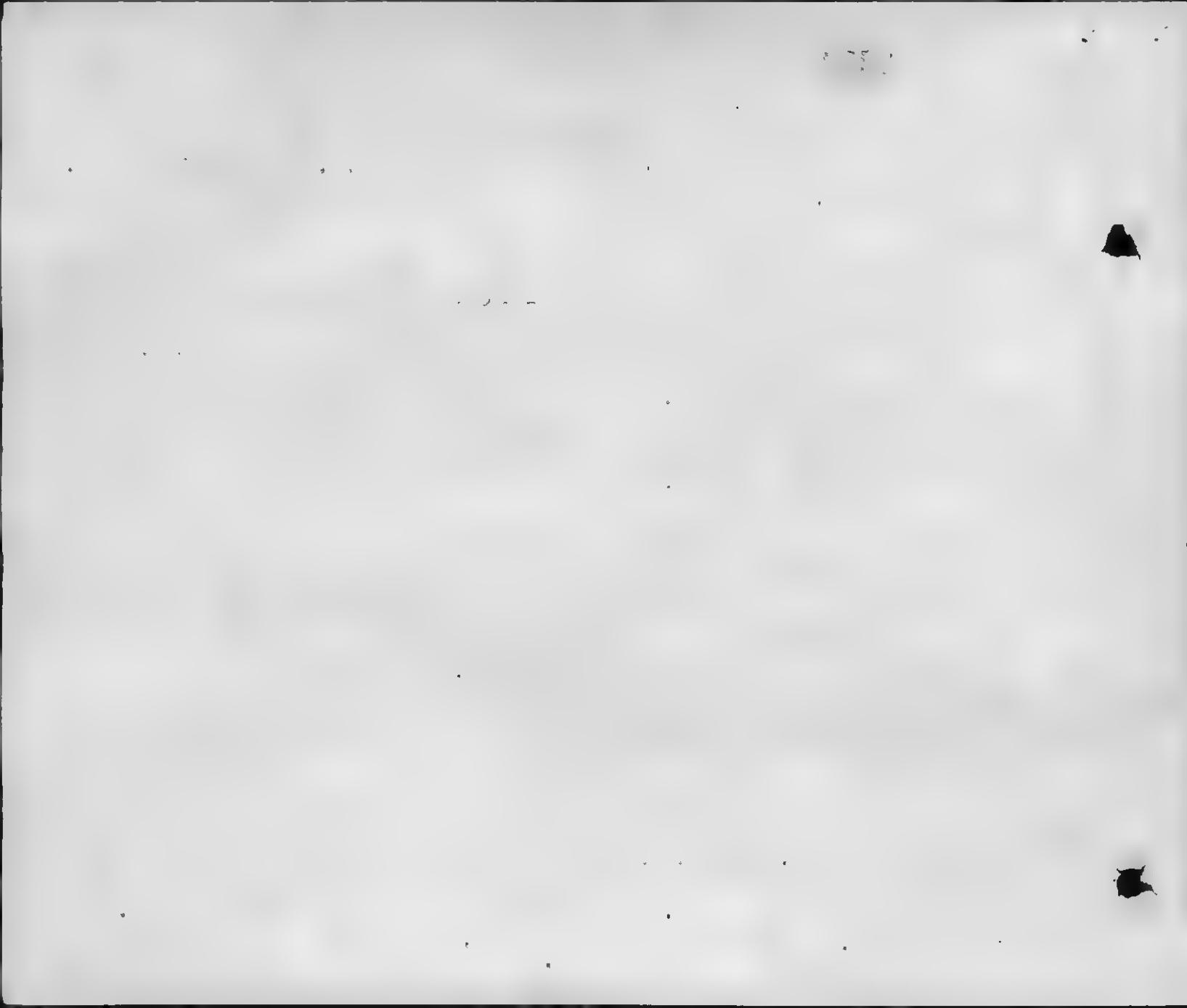
ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

7/7/61



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8333

08327

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Prince Georges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Riverdale

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Leland Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

Grace

5 SEX

Female

6. COLOR OR RACE

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Photographic Oil Artist

10b. KIND OF BUSINESS OR INDUSTRY

Self employed

11. BIRTHPLACE (County & State, or foreign country)

Cherryville, Kansas

13. FATHER'S NAME

James C. Imel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) [If yes give rank or dates of service]

No

16. SOCIAL SECURITY NO.

579-14-1575

17. INFORMANT

Mr. Howard Ralph Hall 6209 Beale Circle

Riverdale, Maryland

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

154 DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

(b) DUE TO

154

(c) DUE TO

154

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

White

Not White

at work

at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) attended the deceased from

7/24/61 to 7/25/61, that (I) last

saw the deceased alive on 7/25/61, and that death occurred at 8:30 A.M. from the causes and on the date stated above.

22e. SIGNATURE

Wm. A. Holbrook

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

4500 College Ave., College Park, Md.

(State)

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

7/28/61

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

Fort Lincoln Cemetery

23d. LOCATION (City, town or county)

Montgomery County, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Warner E. Pumphrey, Inc.

Raymond J. Ziskin

Silver Spring, Maryland

ADDRESS

8434 Georgia Avenue

Silver Spring, Maryland

DATE JUL 28 '61

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

DATE

Month

Day

Year

1961

e. IS RESIDENCE
ON A FARM?
YES NO

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. MOTHER'S MAIDEN NAME

Sarah Warren

19. WAS AUTOPSY
PERFORMED?

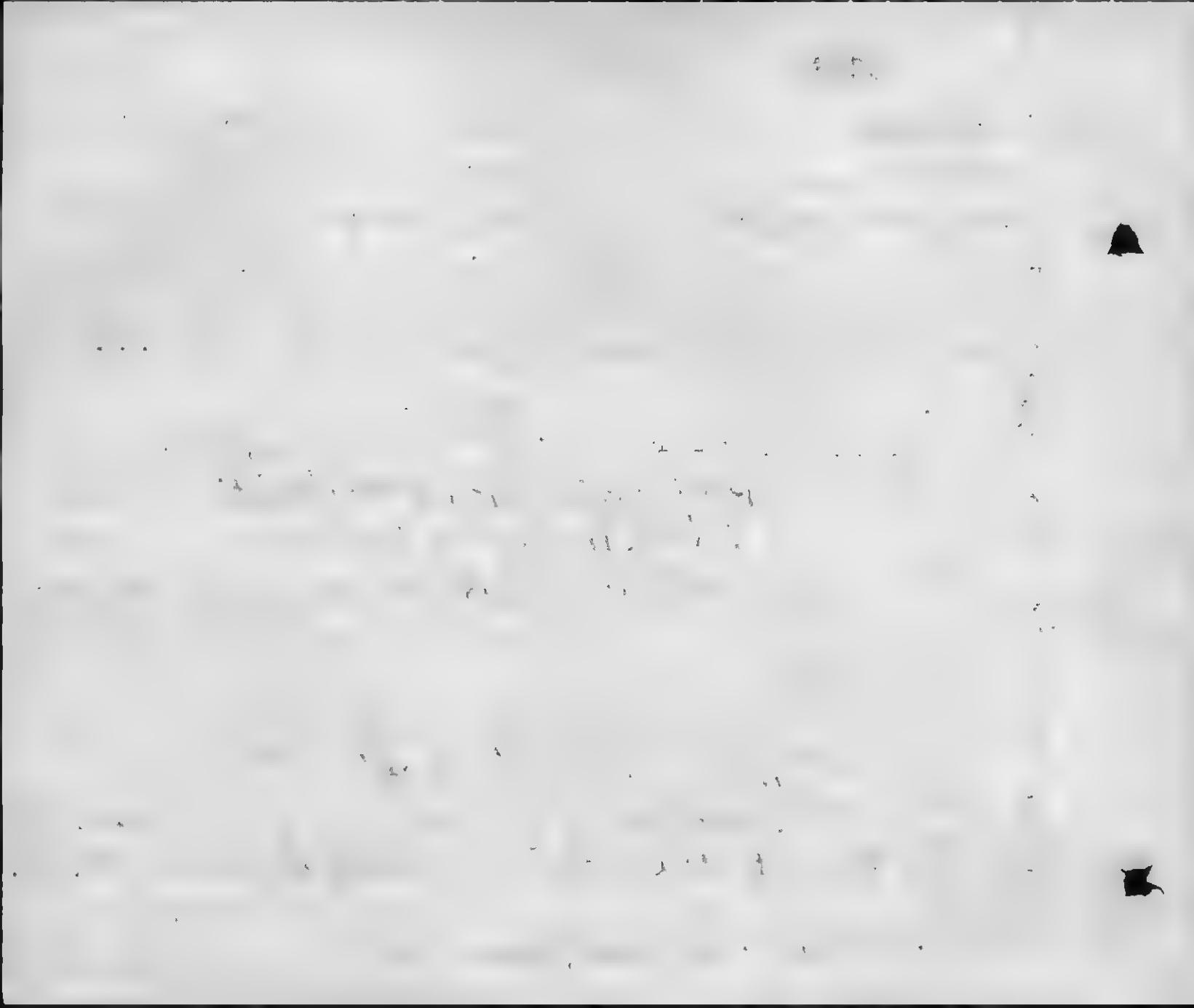
YES NO

INTERVAL BETWEEN
ONSET AND DEATH

1 day

1 wk.

6 mos.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

88323

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bowie	d. COUNTY Prince Georges	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Baby Boy	First Hamilton	Last July	Month 1	
4. DATE OF DEATH 1961	Day 1	Year 1961		
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 June 1961	
9. AGE (in years last birthday) yrs. 2	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY Maryland	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Charles H			
14. MOTHER'S MAIDEN NAME Heleh	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.	17. INFORMANT	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-29 1961 to 7-1 1961 , that (I) (we) last saw the deceased alive on 7-1 1961 , and that death occurred at 3,47 AM from the causes and on the date stated above				22b. DATE SIGNED
22a. SIGNATURE John W. Perkins		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Dr. John Perkins	22d. ADDRESS			
23a. BURIAL / CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 7-10-61	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Prince George's Gen. Hosp.	23d. LOCATION (City, town, or county) Cheverly, Md.	(State)
24. FUNERAL DIRECTOR'S SIGNATURE George W. Parsons	ADDRESS		25a. REC'D BY REGISTRAR DATE JUL 11 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



FOR STATE
HEALTH DEPT.
M

TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

V.S. ATSM
SM 9/60

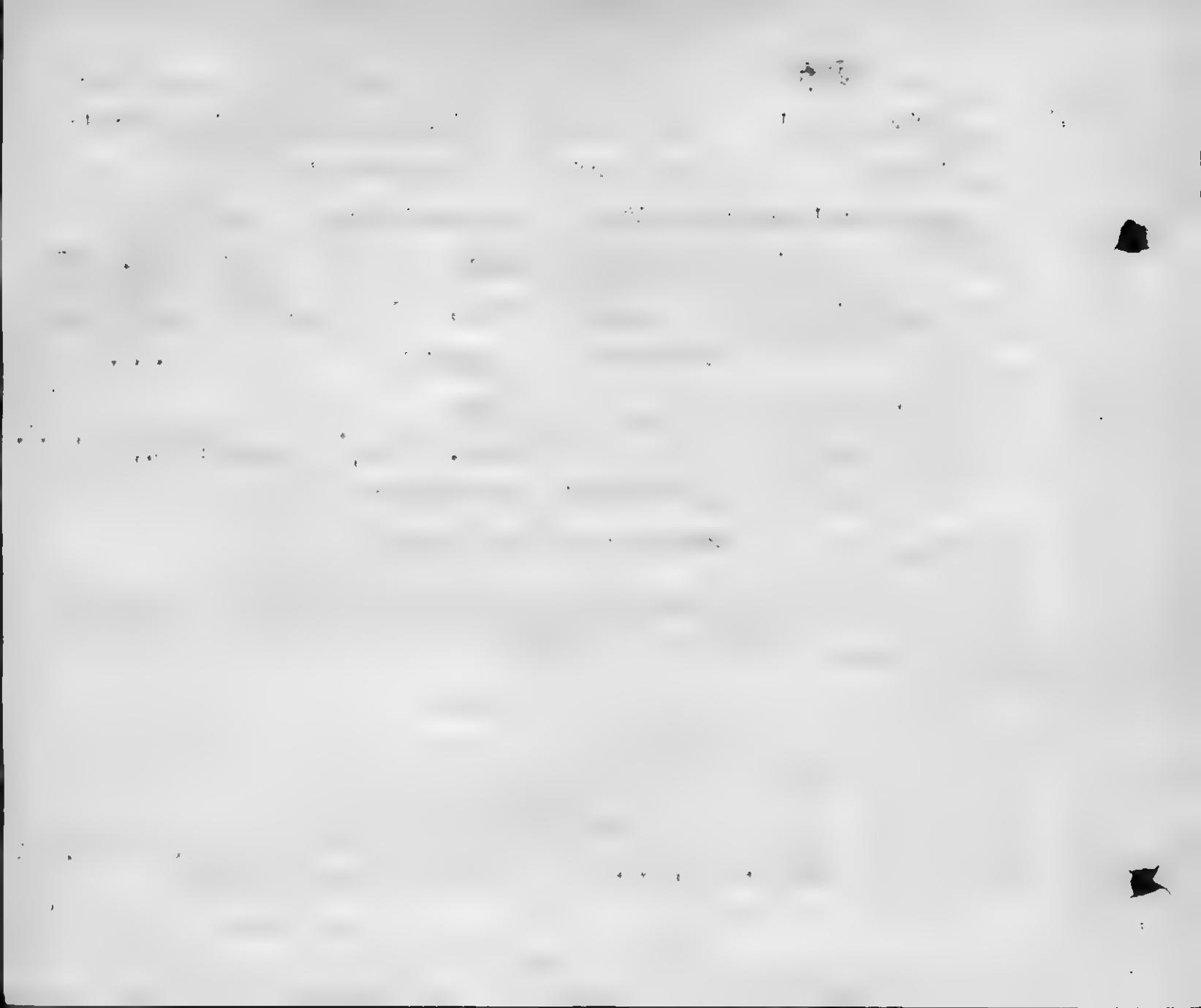
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8335

02220

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution, Resided before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's	
c. LENGTH OF STAY IN 1b Dead on arrival		d. STREET ADDRESS Seat Pleasant	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ellis		4. DATE DEATH July 11th, 1961	
First Middle		Month Day Year	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1901	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY Contractor	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Hanback		14. MOTHER'S MAIDEN NAME Anna Lee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give rank or dates of service) No		16. SOCIAL SECURITY NO. Jr. Ellis D. Hanback, 7410 Halleck St.	
17. INFORMANT None		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) + 45 X Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Acute Congestive Heart Failure Cardiovascular Renal Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-61	
22c. NAME OF CEMETERY OR CREMATORIUM St. Matthew Chapel Ctr.		22d. LOCATION (City, town, or county) Seat Pleasant Md	
23. FUNERAL DIRECTOR J. W. Lees - 300-42st N.W. Wash. D.C.		24a. REC'D BY REGISTRAR DATE JUL 13 '61	
ADDRESS Lees - 300-42st N.W. Wash. D.C.		24b. REGISTRAR'S SIGNATURE C. L. W. S. Times	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8336 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08336

FOR STATE
HEALTH DEPT.delay is necessary,
please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to
TO FUNERAL DIRECTOR: Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 16

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
DECEASED
(Type or print)
First Middle

George

Eugene

Harbaugh

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

February 10, 1915

9. AGE (In years
last birthday)10. US/JAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

46 yrs.

Months

Days

Hours

Min.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Building Superintendent P.E.P.Co

Pennsylvania

13. FATHER'S NAME

Ernest A. Harbaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

yes World War #2 578-09-1973

16. SOCIAL SECURITY NO. 17. INFORMANT

14. MOTHER'S MAIDEN NAME

Evelyn Starner

Address

James A. Harbaugh, 5006 Olympia Ave.,
Beltsville, Md.INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

ASPHYXIA and extensive body burns

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20c. TIME OF INJURY Month, Day, Year

11-12 Hour a.m. July 15 1961

p.m.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Found dead in burning car

20d. INJURY OCCURRED

White Not White

at work at work

Along highway

factory, street, office bldg., etc.)

20e. PLACE OF INJURY (Home, farm,

20f. (City or town)

(County) (State)

GREENBELT MD

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opiniondeath resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER MD ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

7/16/61

ACTUAL
SIGNATURE

James L. Boyd

EXAMINER'S
NAME (Type)22a. NAME OF CEMETERY OR CREMATORIUM
22b. LOCATION (City, town, or country)

REMOVAL (Specify) July 18, 1961 Gate of Heaven Cemetery Silver Springs, Md. (State)

23. FUNERAL DIRECTOR

F. Gasch's Sons Hyattsville, Md.

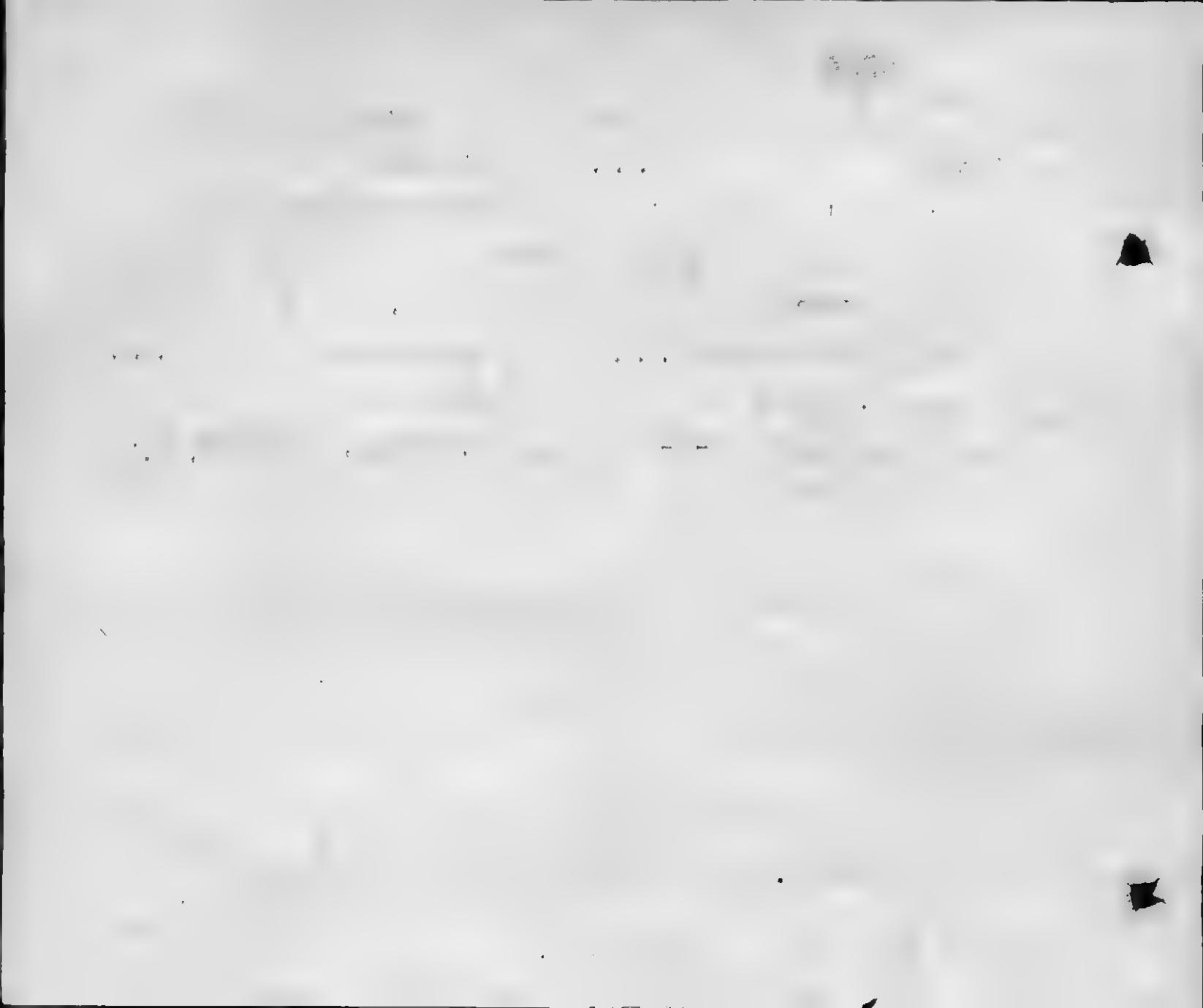
ADDRESS

24a. REC'D BY REGISTRAR

DATE JUL 19 '61

24b. REGISTRAR'S SIGNATURE

Clint G. Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, if filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
M
I

1
M
I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 21201

CERTIFICATE OF DEATH

8337

PLACE OF DEATH

a. COUNTY Prince Georges Co.

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb
13 da.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2601 Cheverly Avenue
Accordia Nursing Home

3. NAME OF
DECEASED
(Type or print)

Mary

Lou

Harper

First Middle

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9/8/1884

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired-Seamstress Dept. store

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE, County & State, or foreign country

Pinson, Tenn.

13. FATHER'S NAME

William Henry Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

no

16. SOCIAL SECURITY NO. (If yes give rank or grade of service)

17. INFORMANT

411-16-1985 Mrs. C.G. Morris - same as above

Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.0

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

CONGESTIVE HEART FAILURE

ARTERIOSCLEROTIC HEART DISEASE

GENERALIZED ARTERIOSCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

CEREBRAL THROMBOSIS - 1 year ago

INTERVAL BETWEEN
ONSET AND DEATH

2 days

4 years

7 years

20e. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II of line 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

p.m.

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (This Hospital) attended the deceased from ... Jun 1956 to Jun 1961, that (I) () last saw the deceased alive on ... Jul 1961, and that death occurred at 7:05P.M. from the causes and on the date stated above.

22e. SIGNATURE

Thomas G. Maloney

M.D.

ATTENDING PHYS.

M.D.

DIRECTOR

STAFF PHYS.

22b. DATE SIGNED
1 Jul 61

22c. PHYSICIAN'S NAME (Type)

THOMAS G. MALONEY M.D.

22d. ADDRESS

41814-71st Ave

Landover Hills Md.

(Streets)

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

7/5/61

23b. DATE THEREOF

7/5/61

23c. NAME OF CEMETERY OR CREMATORIUM

Washington Nat'l

23d. LOCATION (City, town or county)

Prince Georges Co. Md.

(Streets)

24 FUNERAL DIRECTOR'S SIGNATURE

The S. H. Hines Co.

ADDRESS

Washington, D.C.

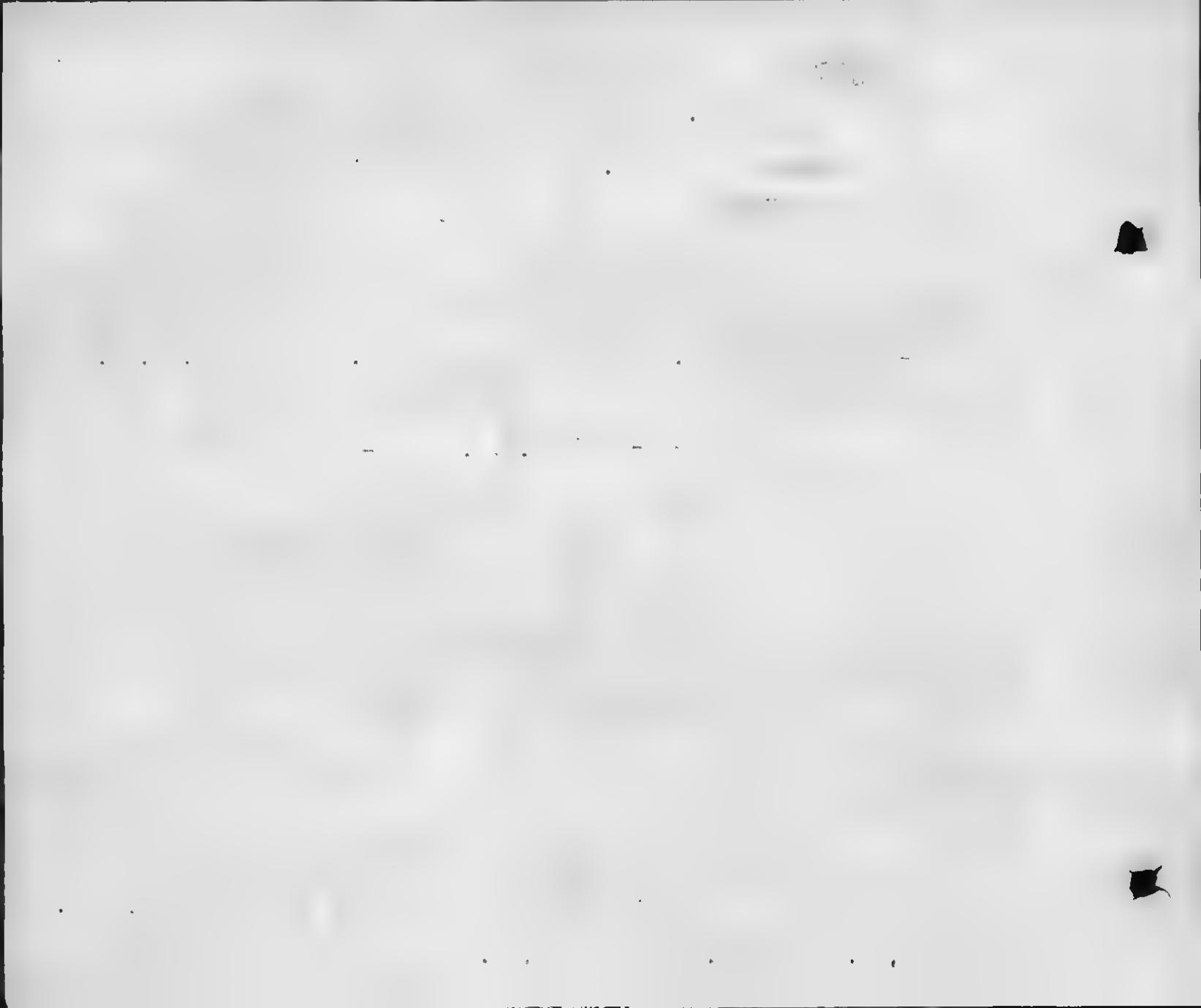
25a. REC'D BY REGISTRAR

DATE JUL 5 '61

25b. REGISTRAR'S SIGNATURE

Clinton S. Hines

(Signature)



1
FOR STATE
HEALTH DEPT.

M

Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used as a burial transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08332

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

c. LENGTH OF STAY IN lb

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rivendale

13 hrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Eugene Leland Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

Mary

Elizabeth

Hasko

5. SEX

6. COLOR OR RACE

Female

White

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

Own Home

13. FATHER'S NAME

Patrick Henry Moran

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes, give rank or grade of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

491X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

578-28-0539 Richard H. Pugh, West Minister Md
PNEUMONIA, RIGHT. MIDOLS - and
Right Lower Lobes

Scammon, 163 Penn Ave.,

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22a. BURIAL, CREMATION
REMOVAL (Specify)

Burial
23. FUNERAL DIRECTOR

Francis J. Collins

Francis J. Collins 3821 14th St., N.W.

DATE

7-10-61

22c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cemetery

ADDRESS Wash. D.C.

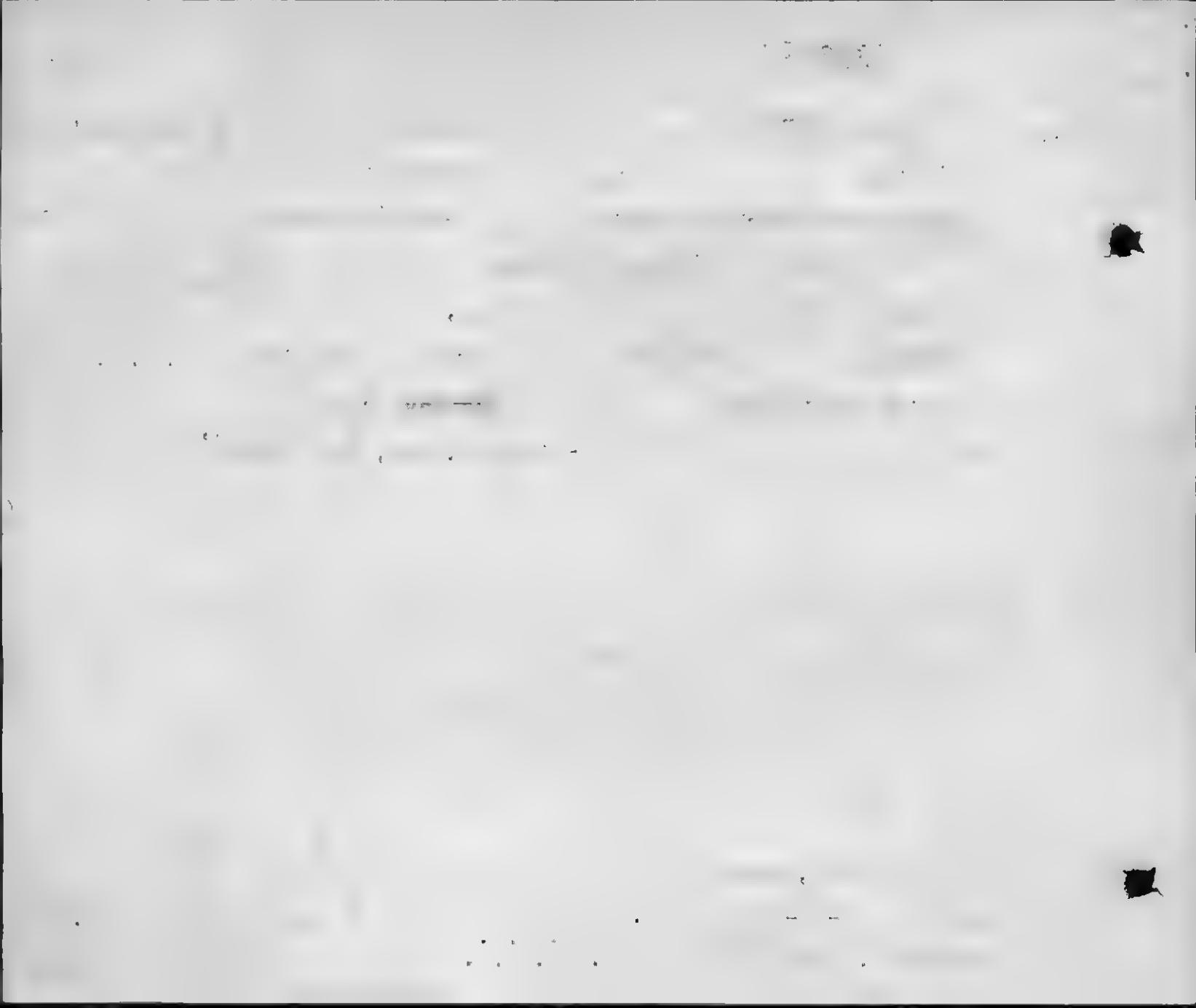
24a. REC'D BY REGISTRAR JUL 10 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Trahan

DATE

7-10-61



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

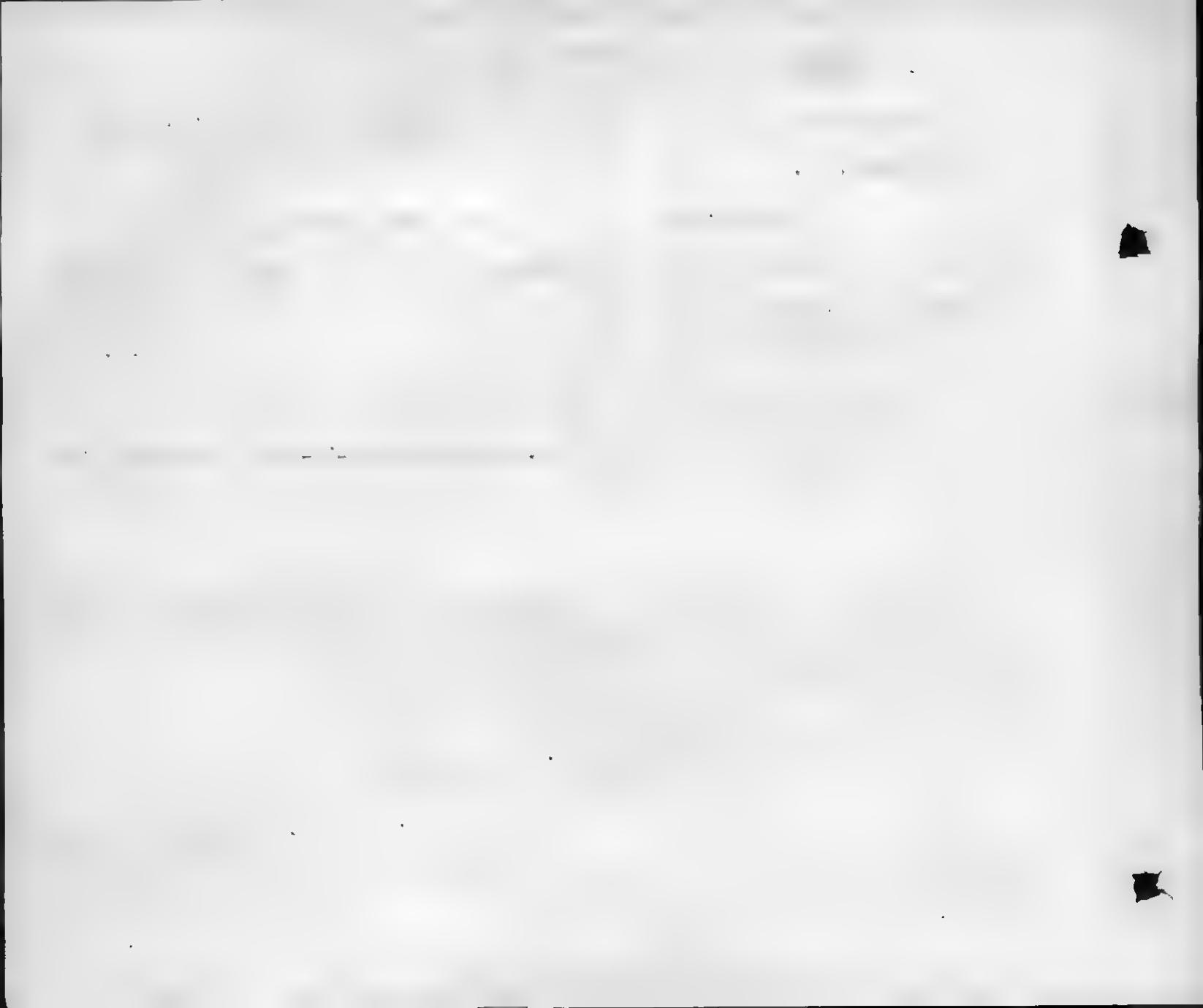
8339

CERTIFICATE OF DEATH

Reg. Dist. No.

08339

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland, Md.		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4473 Forte Drive				d. STREET ADDRESS 4473 Forte Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lela		First	Middle	Lost	4. DATE OF DEATH July 26 1961	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1883	9. AGE (In years last birthday) yrs. 77	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Franklin Keller		14. MOTHER'S MAIDEN NAME Elmira Skidmore							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 292-24-6858		17. INFORMANT Mr. Byron Pope (Son-in-law) 4473 Forte Drive	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. { DUE TO (b) Mesenteric thrombosis DUE TO (c) Coronary insufficiency (MI) (years) Arteriosclerotic heart disease (years)						INTERVAL BETWEEN ONSET AND DEATH 17 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fibrillation							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 1200 22nd & E. Lake		20f. (City or town) D.C.		(County) W.M. Sheer	(State) 9-26-61
21. I certify that I attended the deceased from 12-28 , 19 59 , to 7-26 , 19 61 , that I last saw the deceased alive on 7-26-61 , 19 61 , and that death occurred at 5:15 PM , from the causes and on the date stated above						ADDRESS (Street, city or town, state) W.M. Sheer			DATE SIGNED 9-26-61
ACTUAL SIGNATURE W.H. Sheer									
PHYSICIAN'S NAME (Type) WALTER B. SHEER									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 29, 1961		22c. NAME OF CEMETERY OR CREMATORIAL North Cem,		22d. LOCATION (City, town, or county) West Mansfield Ohio		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Lee - 300-44 St. N.E. Wash D.C.		ADDRESS		24a. RECEIVED BY REGISTRAR JUL 28 1961		24b. REGISTRAR'S SIGNATURE Arthur L. Turner			



1
FOR STATE
HEALTH DEPT.

M

Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TOMBSTONE: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designee agent, prior to burial, cremation, or removal, in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8340

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08334

1. PLACE OF DEATH
a. COUNTY

Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb
100-a

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
MILDRED
(Type or print)

Mildred Taylor

4. SEX

5. COLOR OR RACE

6. MARRIED

7. MARRIED

WIDOWED

DIVORCED

Female White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Housewife

Own Home

13. FATHER'S NAME

Emmett Cleveland Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give war or dates of service]

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Ernest Frederick Hauser Jr , Same as #

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1/ 20 DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

(b)

DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. p.m.

19

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

JAMES I. BOYD, M.D.

22a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

22b. DATE THEREOF

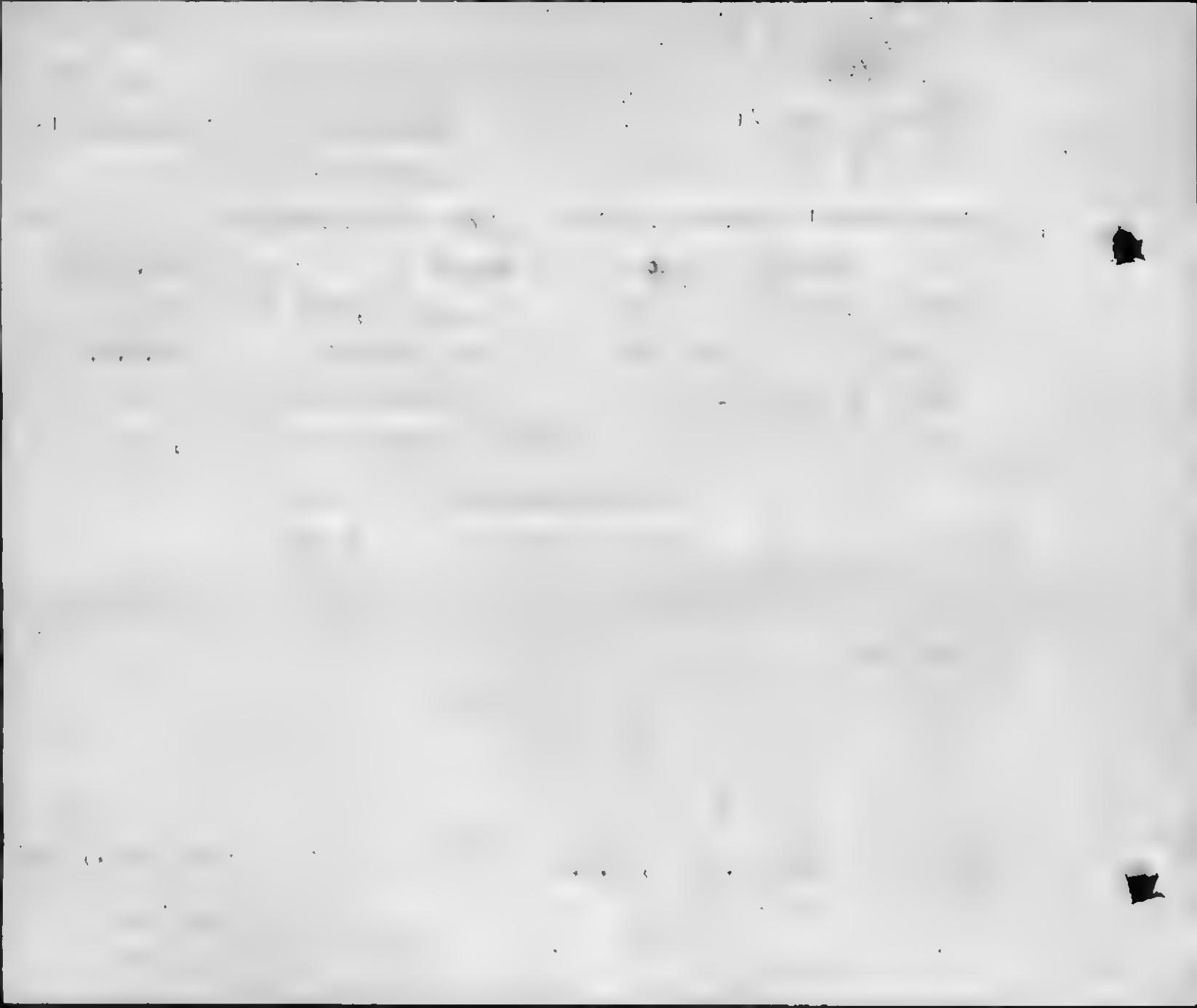
July 22, 1961

Ft Lincoln Cemetery

22c. NAME OF CEMETERY OR CREMATORIUM

Colmar Manor, Md.

22d. LOCATION (City, town, or country) (State)



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08335

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cottage City

c. LENGTH OF STAY IN lb

3713 - 37th Avenue

First Middle

3. NAME OF
DECEASED
(Type or print)

James Gordon

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cottage City

d. STREET ADDRESS

3713 - 37th Avenue

Last

4. DATE
OF
DEATH

July 30th, 1961

5. SEX

6. COLOR OR RACE

Male White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

July 29th, 1919

9. AGE (In years
last birthday)
42 yrs.

10. IF UNDER 1 YEAR

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Pressman

10b. KIND OF BUSINESS OR INDUSTRY

Gov't

U.S. Printing

11. BIRTHPLACE (State or foreign country)

District of Columbia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William A. Helm

14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No.

15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Hemorrhage and Shock

Gunshot wound of mouth

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Placed shot gun and fired it

in mouth

20c. TIME OF INJURY Month, Day, Year

Hour 3:30

19 61

20d. INJURY OCCURRED While Not While

at work at work

20e. PLACE OF INJURY (Home, farm, 20f. (City or town)

factory, street, office bldg., etc.)

Home

(County) (State)

Cottage City P.G. Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE

JAMES I. BOYD, M.D.

EXAMINER'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

8-2-1961

22c. NAME OF CEMETERY OR CREMATORIAL

Fort Lincoln Com. Bladensburg Maryland

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR

A.W. Chambers Co.iversdale Md.

ADDRESS

24a. REC'D. BY REGISTRAR

AUG 2 '61

24b. REGISTRAR'S SIGNATURE

James S. Thomas

DATE

delay is necessary,

please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page

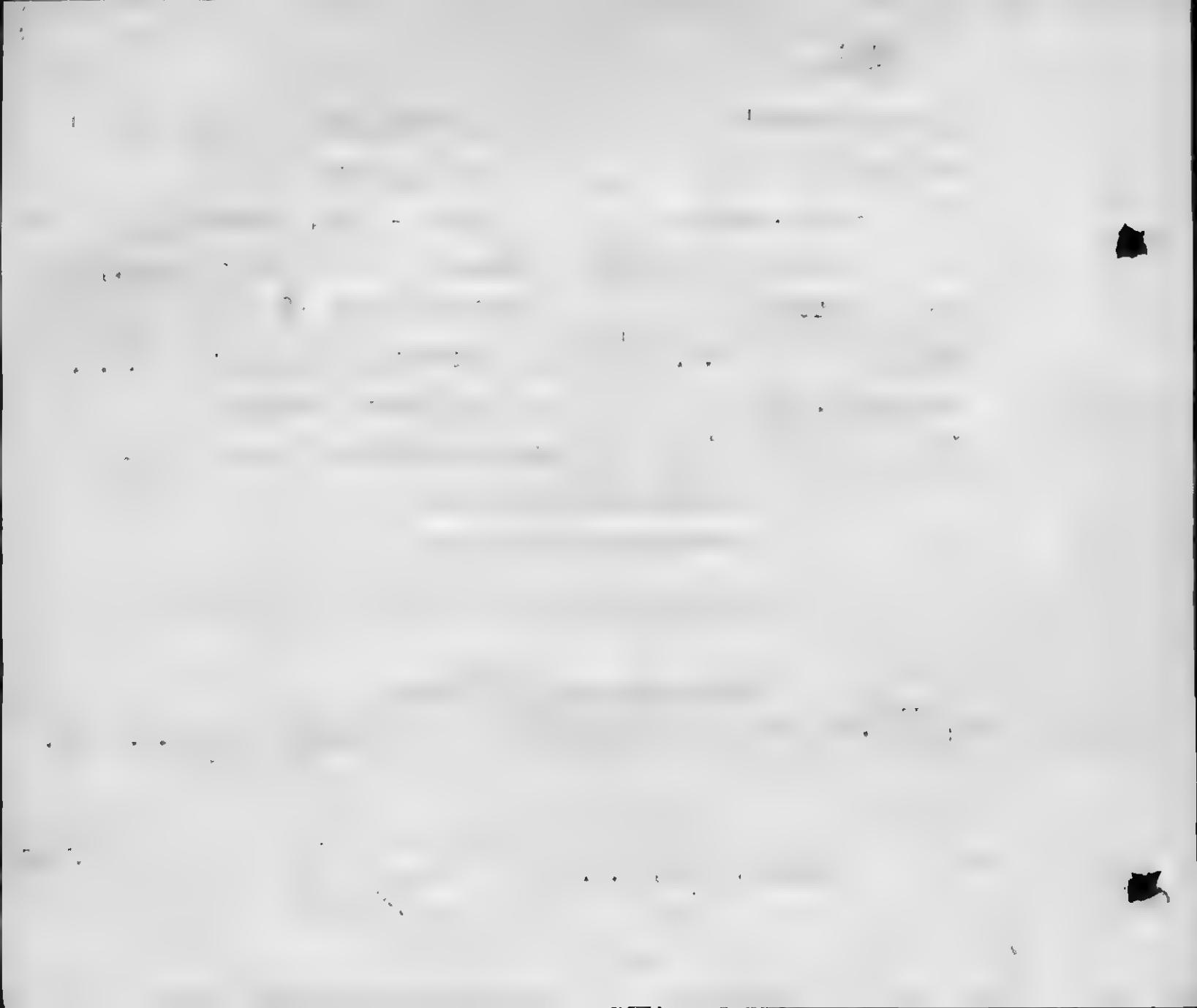
4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,

or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME

5M 9/60



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8342 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08336

1. PLACE OF DEATH
a. COUNTY

Prince George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cheverly

MARYLAND

c. LENGTH OF STAY IN lb

2 hrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's

3. NAME OF
DECEASED
(Type or print)

First

Middle

Helen

Irene

Herb

4. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

February 19, 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Own Home

Pennsylvania

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Harry Sausser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1. ~~72~~ DUE TO

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AN AUTOPSY PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 19

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED
7/2/61

ACTUAL
SIGNATURE

James J. Boyd

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. LOCATION (City, town, or county)

(State)

Burial July 5, 1961 Friedens Union Cem. Hegins, Pa.

23. FUNERAL DIRECTOR

ADDRESS

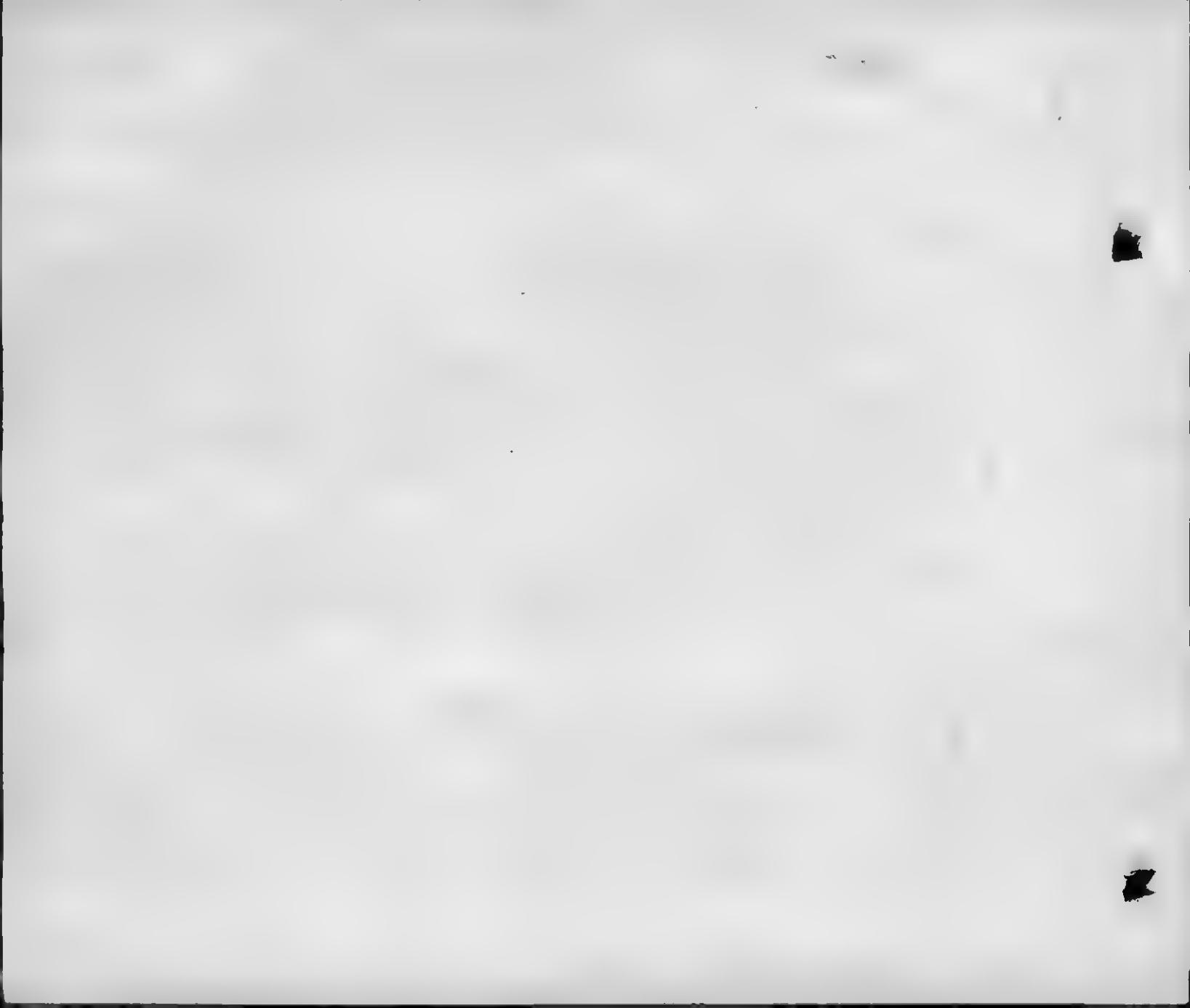
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE

JUL 5 '61

Lee & Thomas



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08337

1. PLACE OF DEATH COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arondale</i>	c. LENGTH OF STAY IN lb <i>70 years</i>	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arondale, Maryland 49</i>	c. LENGTH OF STAY IN lb <i>70 years</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2020 Woodlawn Road</i>	e. STREET ADDRESS <i>2020 Woodlawn Road</i>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CLARENCE HERMAN</i>	Middle <i>WILSON HERMAN</i>	4. DATE OF DEATH <i>July 10th</i>	Month <i>July</i> Day <i>10</i> Year <i>1961</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/26/1894</i>
9. AGE (In years last birthday) <i>66</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. IF UNDER 24 HRS. Minutes <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Linotype</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Up Government</i>	11. BIRTHPLACE (State or foreign country) <i>Carlisle, Anna</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>Harry W. Herman</i>	14. MOTHER'S MAIDEN NAME <i>Mary Frances Baker</i>	Address <i>William C. Herman above</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>William C. Herman</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis & myocardial infarction</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>coronary artery disease</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>			
18 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov. 1959</i> to <i>7/10/1961</i> that I last saw the deceased alive on <i>7/2 1961</i> , and that death occurred at <i>150 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Hugh W. Grey</i>		ADDRESS (Street, city or town, state) <i>7105 - RIGGS RD, HYATTSVILLE, MD</i>	
		DATE SIGNED <i>7/10/61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/13/61</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cemetery</i>
22d. LOCATION (City, town, or county) <i>Arlington, Virginia</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley's Funeral Home</i>		24a. REC'D BY REGISTRAR ADDRESS <i>Mt. Rainier, Md.</i>	24b. REGISTRAR'S SIGNATURE <i>C. E. Kraus</i>
		DATE <i>JUL 13 '61</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH				8344							
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland b. COUNTY Prince George							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b 2 years							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5602 Queenschapel Road				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville							
f. STREET ADDRESS 5602 Queenschapel Road								g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mrs Grace		First mrs Middle Grace		Last Hoffman		4. DATE OF DEATH July 25 1961		Month July		Day 25	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/9/1883		9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME William McLuckie				14. MOTHER'S MAIDEN NAME Ida Virginia Gunnett				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. <small>If yes, give war or dates of service</small>		17. INFORMANT Trusdon Cannon		4021 Longfellow Street Hyattsville, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Adeno CANCEROMA OF STOMACH											
DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from June 1960 to July 25, 1961 , that (I) (we) last saw the deceased alive on July 25, 1961 , and that death occurred at 11 AM from the causes and on the date stated above											
22a. SIGNATURE Norman Dowd Comeau				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/25/61	
22c. PHYSICIAN'S NAME (Type) Norman Dowd Comeau				22d. ADDRESS 3503 Penny St Mt Rainier MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/28/61		23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery				23d. LOCATION (City, town, or county) Easton Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons						ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 3 '61		25b. REGISTRAR'S SIGNATURE C. Guy L. Kline	



FOR STATE
HEALTH DEPT.

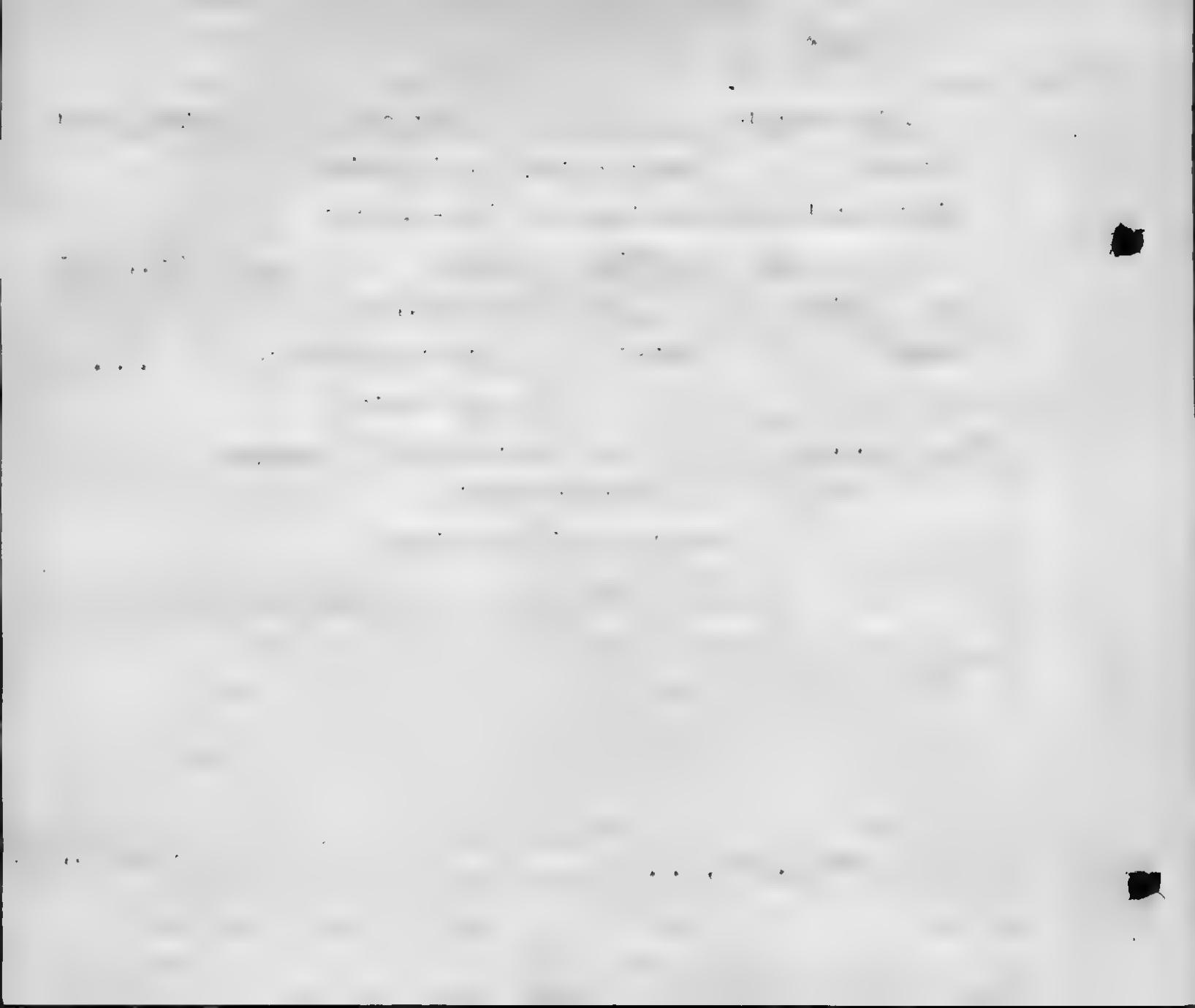
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8345 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08339

1. PLACE OF DEATH a. COUNTY Prince George's	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake	c. LENGTH OF STAY IN lb Dead on arrival	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Capitol Heights	d. STREET ADDRESS 6402 - A Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital	First John	Middle Hopkins	Last Holden			
3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH Month July	Month Day	Year 7th., 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 23rd., 1893			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) District of Columbia	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Holden	14. MOTHER'S MAIDEN NAME Anne Hopkins	Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) Yes W.W. I	16. SOCIAL SECURITY NO.	17. INFORMANT Georgie Holden	18. CRUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion			
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		DUE TO Arteriosclerotic Heart Disease				
DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>James I. Boyd</i>	CHIEF MEDICAL EXAMINER M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED July 8th., 1961	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) Arlington Hall 2A Meyer, Va.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-11-1961	22c. NAME OF CEMETERY OR CREMATORIAL Washington D.C.	22d. LOCATION (City, town, or county) Wash D.C.	(State)		
23. FUNERAL DIRECTOR Robert A. Mattingly	ADDRESS 131-118th St.	24a. REC'D BY REGISTRAR JUL 10 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Evans			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8346

CERTIFICATE OF DEATH

Reg. Dist. No. 08340

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forestville Nursing Home		d. STREET ADDRESS 3237 Hiatt Place, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Virginia	Middle M.	Last Howdershell
4. DATE OF DEATH	Month July	Day 22,	Year 19 61
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 7/16/1883	9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Alexandria, Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Cogan		14. MOTHER'S MAIDEN NAME --- Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 577-07-0882D 17. INFORMANT Address Records at Nursing Home - Forestville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yr Occurrence of coronary artery arteriosclerosis of coronary artery 1 year generalized arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-1-1960 to 7-22-1961, that I last saw the deceased alive on 7-21-1961, and that death occurred at 3:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE RICHARD GITTER M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) RICHARD GITTER NASH, 3, D.C. DATE SIGNED 7-22-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/25/61	22c. NAME OF CEMETERY OR CREMATORIAL Presbyterian Cemetery	22d. LOCATION (City, town, or county) Alexandria, Virginia (State)
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St., N.W. Washington, D.C.	24a. REC'D BY REGISTRAR DATE JUL 25 '61
			24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8347

CERTIFICATE OF DEATH

28347

1. PLACE OF DEATH

e. COUNTY Prince Georges

MARYLAND

b. CITY OR TOWN (if out's do corporate limits, write RURAL and give nearest town)

Glenn Dale (rural)

LENGTH OF STAY IN 1b
2 yrs., 1 mo.
& 20 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, g've street address)

Glenn Dale Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Preston

Hymes

330 Va., Ave., S. E.

7

10

19 61

4. DATE
OF
DEATH

Month

Dey

Year

5. SEX

6. COLOR OR RACE

Male | Negro

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck driver

10b. KIND OF BUSINESS OR INDUSTRY

Potomac Fish Market

11. BIRTHPLACE, County & State, or foreign country

N.C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Cattie Hymes

14. MOTHER'S MAIDEN NAME

Minnie Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year(s) & dates of service)

Yes | 1944 - 1947

16. SOCIAL SECURITY NO. | 17. INFORMANT

1977-18-0782 Decedent

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which

give rise to immediate cause

(b)

DUE TO

(c)

DUE TO

Aspiration left empyema with bronchopleural-

cutaneous fistula

Left upper lobectomy & wedge superior segment left

lower lobe (4/4/61) for far advanced pul. tbc.

7 yrs., 6 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e.)

Diabetes mellitus, partial gastrectomy 1950, right pulmonary decortica-

tion 10/54, right thoracoplasty 1/55.

20c. TIME OF INJURY Month, Day, Year

Hour e.m.

p.m.

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

and that death occurred at P.M.

from the causes and on the date stated above.

22e. SIGNATURE

Moe Weiss

22c. PHYSICIAN'S NAME (Type)

Moe Weiss, M. D.

22b. DATE SIGNED

7/10/1961

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

7-14-61

23c. NAME OF CEMETERY OR CREMATORIUM

Arlington Nat. Cem.

23d. LOCATION (City, town or county)

Arlington

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

John T. Rhines Jr.

3015-15th St. N.W.

D.C.

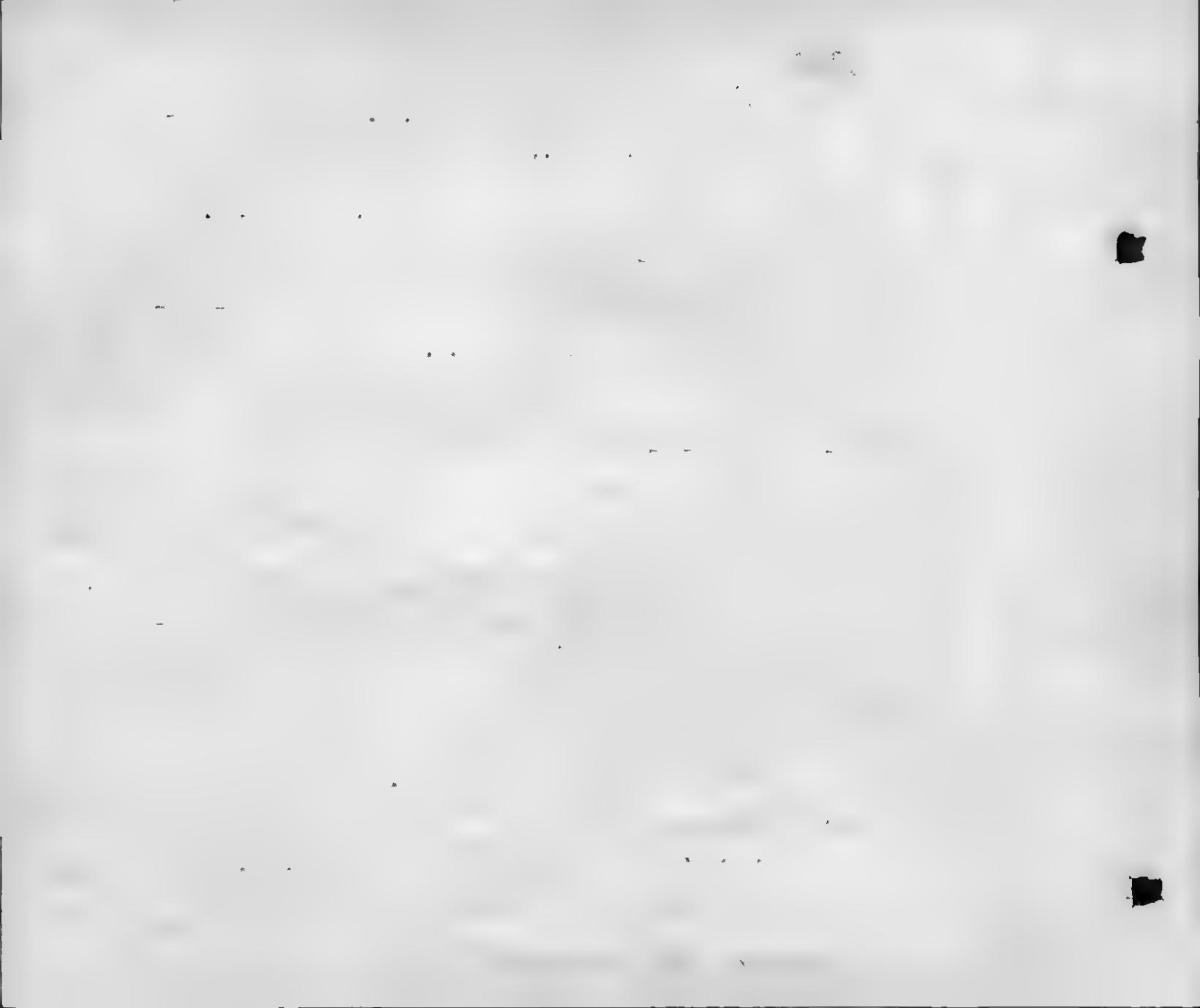
ADDRESS

DATE 11/11/18 '61

25e. REC'D BY REGISTRAR

Arthur L. Thomas

25f. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

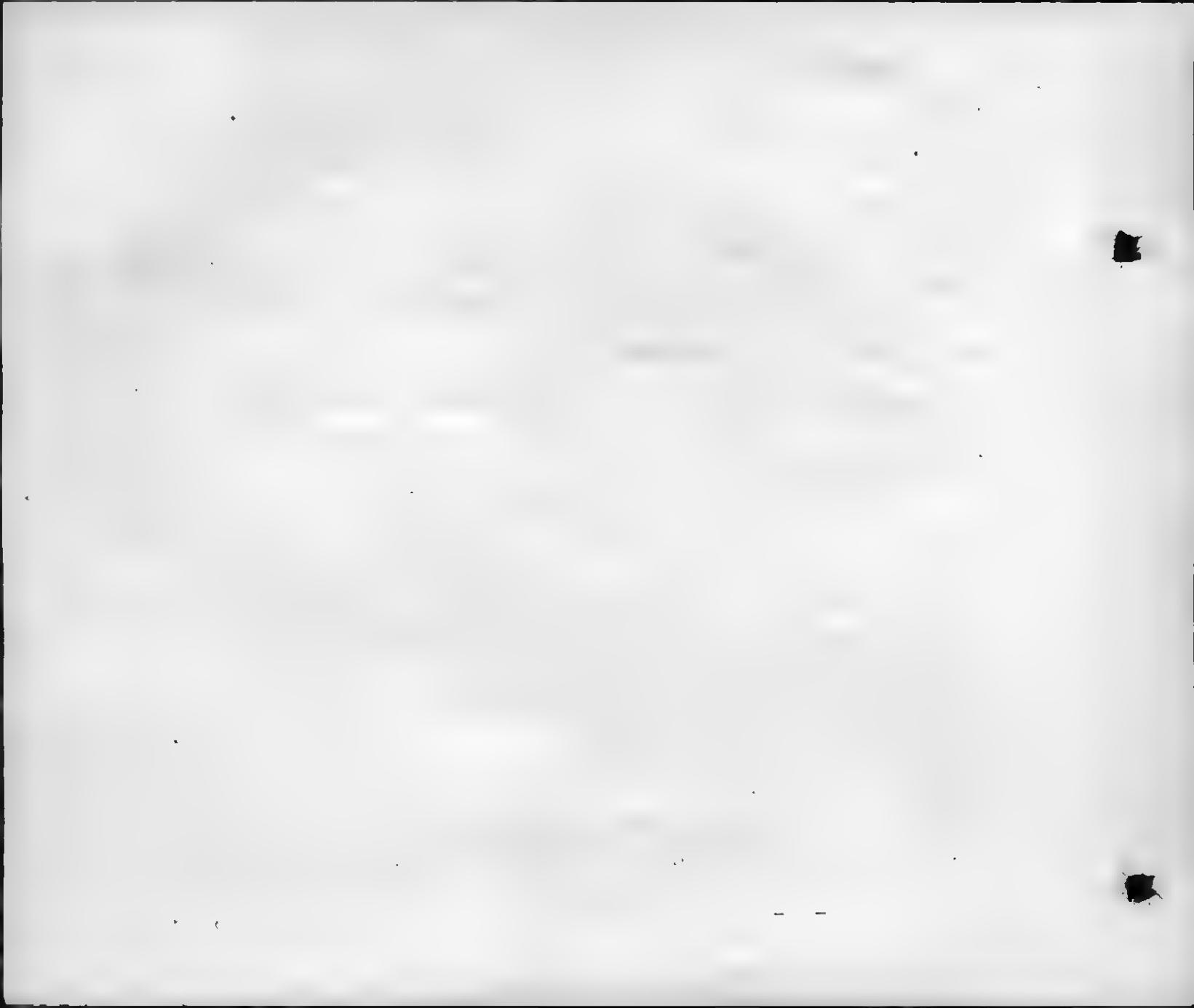
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08342

8348

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>3425-82nd Ave. Prince George, Md.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Suitland</i>		c. LENGTH OF STAY IN 1b <i>23 DAYS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suitland Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Hattie Cox</i>	Middle <i></i>
Last <i>Johnson</i>		4. DATE OF DEATH <i>7/23/1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/4/71.</i>
9. AGE (In years last birthday) <i>89 yrs</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Office Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	
11. BIRTHPLACE (State or foreign country) <i></i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin Cox</i>		14. MOTHER'S MAIDEN NAME <i>Hannah Elizabeth Robinson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Mrs. Geo. C. Miller</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>42D.1</i>	
		DUE TO (b) <i>Aortic Insufficiency, Longstanding</i> DUE TO (c) <i>Anterior Aortic Coronary Interv. Disease 20 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumonia, Pyelonephritis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>July 22, 1961</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on <i>July 22, 1961</i> and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>Kelvin L. Minchin</i>	
22c. PHYSICIAN'S NAME (Type) <i>KELVIN L. MINCHIN M.D.</i>		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>July 23 1961</i>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF <i>7-27-61</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Farmington</i>		23d. LOCATION (City, town, or county) (State) <i>Farmington N. Hampshire</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. L. L.</i>		ADDRESS <i>300 4th St N.E.</i>	25a. REC'D BY REGISTRAR DATE JUL 26 '61
			25b. REGISTRAR'S SIGNATURE <i>C. L. S. Evans</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

M

8349

CERTIFICATE OF DEATH

08343

1. PLACE OF DEATH

a. COUNTY

Prince Georges

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Glenn Dale (rural)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Glenn Dale Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Samuel

5. SEX

Male

6. COLOR OR RACE

Negro

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Odd jobs

13. FATHER'S NAME

Ed Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

Unknown

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

8/11/1898

10b. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (County & State, or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Ida Stewart

Address

16. SOCIAL SECURITY NO.

17. INFORMANT

Decedent

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
(IMMEDIATE CAUSE (b))

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

Pulmonary tuberculosis, far advanced

INTERVAL BETWEEN
ONSET AND DEATH

3 yrs., 7 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Diabetes mellitus; bilateral pyelonephritis; pulmonary emphysema and

fibrosis; early cirrhotic changes in the liver; peripheral vascular **

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER!)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

19

p.m.

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

7/21/1961

and that death occurred at P.M.

from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Moe Weiss, M.D.

23b. DATE THEREOF

REMOVAL (Specify)

7-24-61

23c. NAME OF CEMETERY OR CREMATORIAL

ADDRESS Wash., D.C.

24 FUNERAL DIRECTOR'S SIGNATURE

Malvina Schey Inc. 424 R St. N.E.

MD ATTENDING PHYS.

22d. ADDRESS

MED. DIRECTOR

STAFF PHYS.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

7/22/1961

23d. LOCATION (City, town or county)

(State)

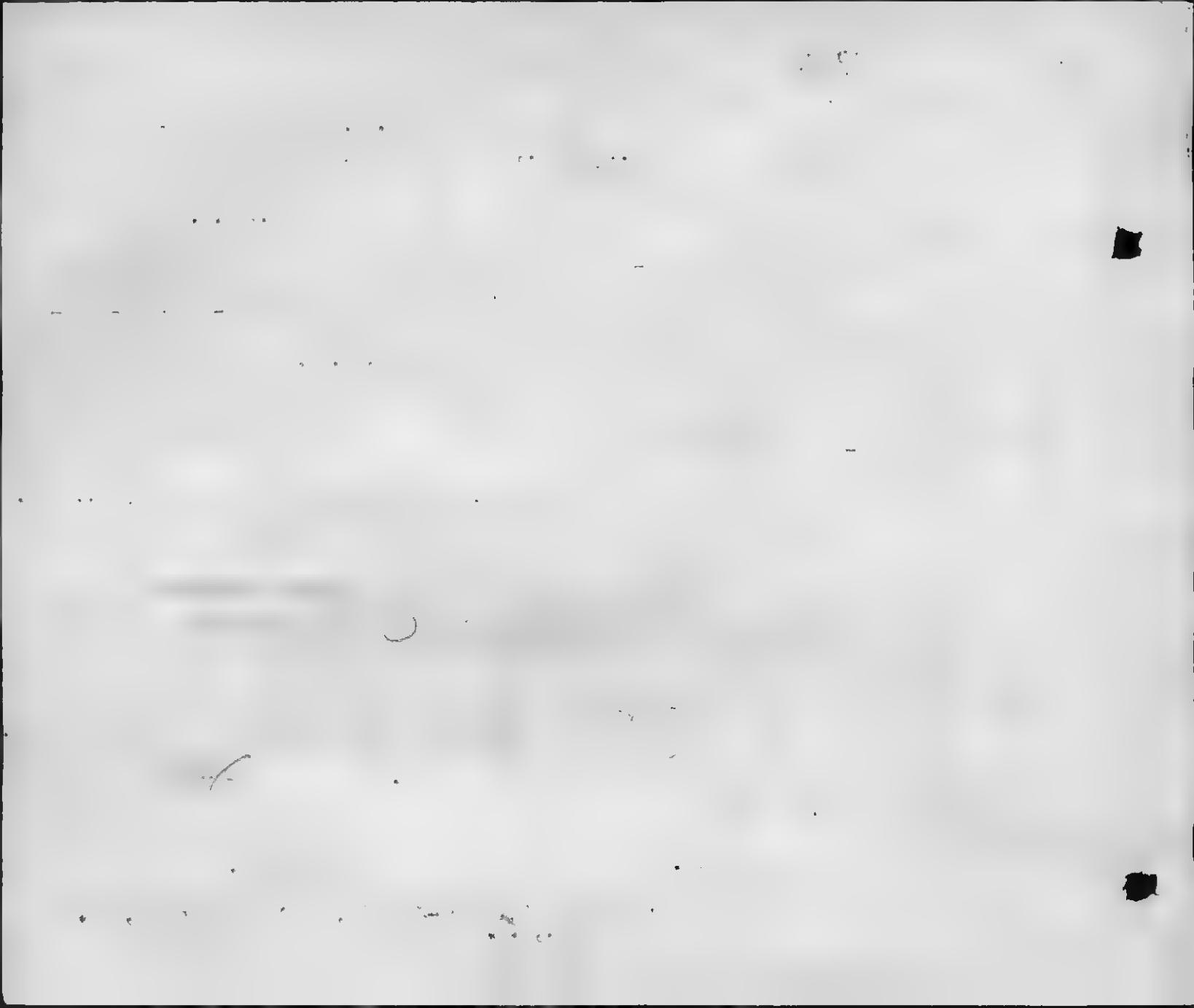
Huntsville, Md.

25a. REC'D BY REGISTRAR

JUL 26 '61

25b. REGISTRAR'S SIGNATURE

Robert S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
(mo.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

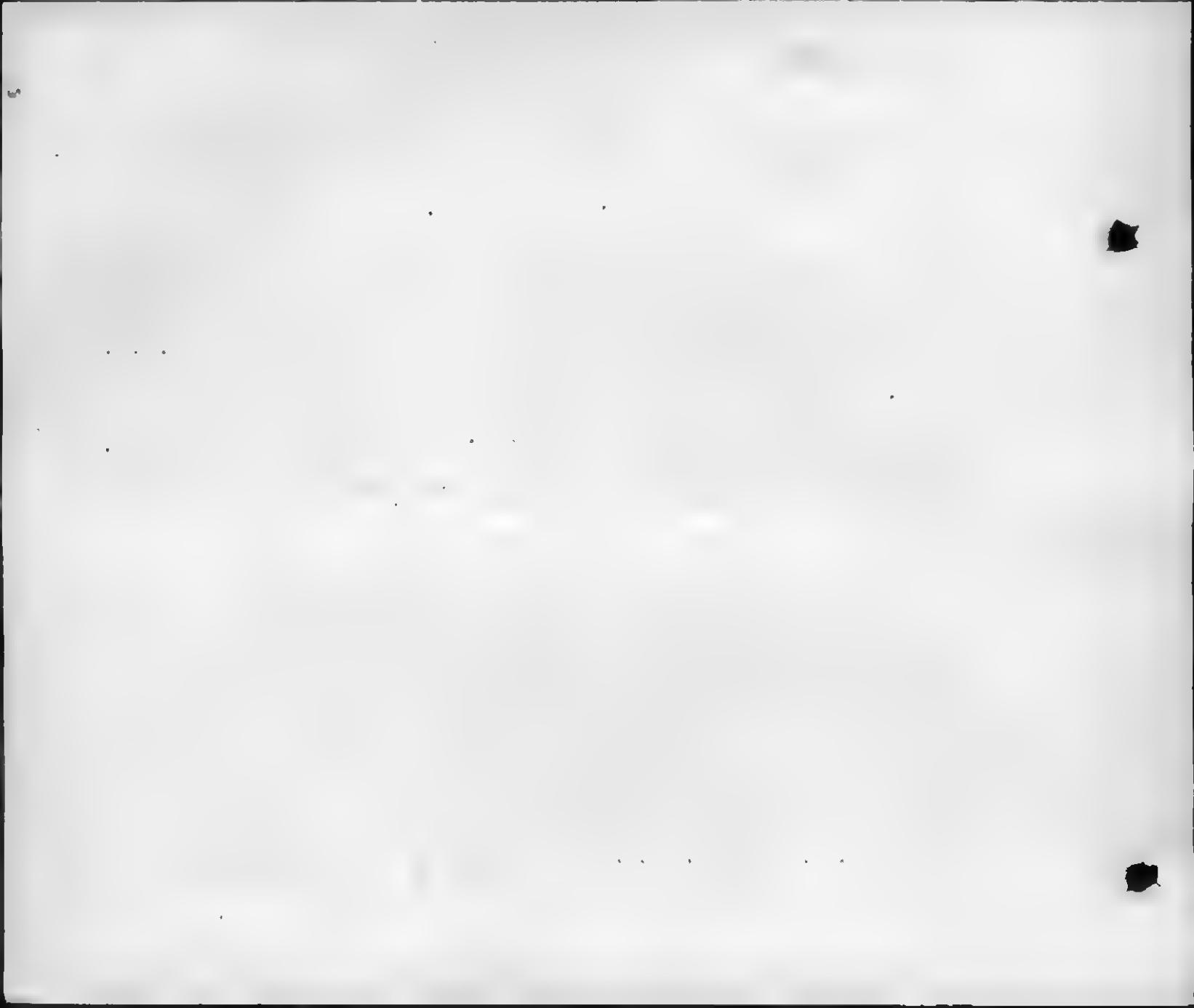
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8350

CERTIFICATE OF DEATH

08344

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		d. STREET ADDRESS Rt. 2 Box 411	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Emmett	Middle L	Last Johnston	4. DATE OF DEATH July 17 1961	Month July	Day 17	Year 1961
S SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 16 June 1899	9. AGE (in years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President		10b. KIND OF BUSINESS OR INDUSTRY Colonial Oldsmobile		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer L. Johnston		14. MOTHER'S MAIDEN NAME Laura Field					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO ?		17. INFORMANT Mrs. H. Lewis Britts		Address 5231 Woodbury St. NW Roanoke, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary arteriovenous shunt</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>central accident (complication)</i> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pulmonary arteriovenous shunt</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury occurred at 6:00 AM from the causes and on the date stated above.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____ from the causes and on the date stated above.							
22a. SIGNATURE <i>Donald D. Mitchell</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 17 1961			
22c. PHYSICIAN'S NAME (Type) Dr. D. Mitchell, M.D.		22d. ADDRESS 1746 K St NW, Wash DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE THEREOF 7/19/61		23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Cemetery		23d. LOCATION (City, town, or county) (State) Roanoke, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>The S.A. Hines Co.</i>		ADDRESS 2901-14 St. S.W.		25a. REC'D BY REGISTRAR DATE JUL 19 '61		25b. REGISTRAR'S SIGNATURE <i>John S. Hines</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8351

CERTIFICATE OF DEATH

Items 3 & 14 Fill in 8351

83345

1. PLACE OF DEATH

a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hyattsville, Riverdale 29 days

c. LENGTH OF STAY IN 1B

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Eugene Island Memorial

3. NAME OF
DECEASED
(Type or print)

First

Middle

Annabelle

L

5. SEX

Female W

10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired)

House w. fe

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED D.VORCED

8. DATE OF BIRTH

9. AGE (in years last birthday)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Own Home

Maryland

13. FATHER'S NAME

William Rogers.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No No

16. SOCIAL SECURITY NO. 17. INFORMANT

(Part I, death was caused by immediate cause (a).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a).170X DUE TO
Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last. (b)DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 20d. INJURY OCCURRED

p.m. 19 While Not While

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (i) (this hospital) attended the deceased from

saw the deceased alive on

July 20 1961

and that death occurred at

3 PM, from the causes and on the date stated above.

22a. SIGNATURE

L W Malin

22c. PHYSICIAN'S NAME (Type)

L W Malin MD

Riverdale, Md.

23a. BURIAL, CREMATION, 23b. DATE THEREOF

REMOVAL (Specify)

Burial July 24, 1961

Oak Hill Cemetery

23c. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

Hyattsville, Md.

23d. LOCATION (City, town or county)

(State)

Washington D C

24 FUNERAL DIRECTOR'S SIGNATURE

F. Gasch's Sons

ADDRESS

Hyattsville, Md.

25a. REC'D BY REGISTRAR

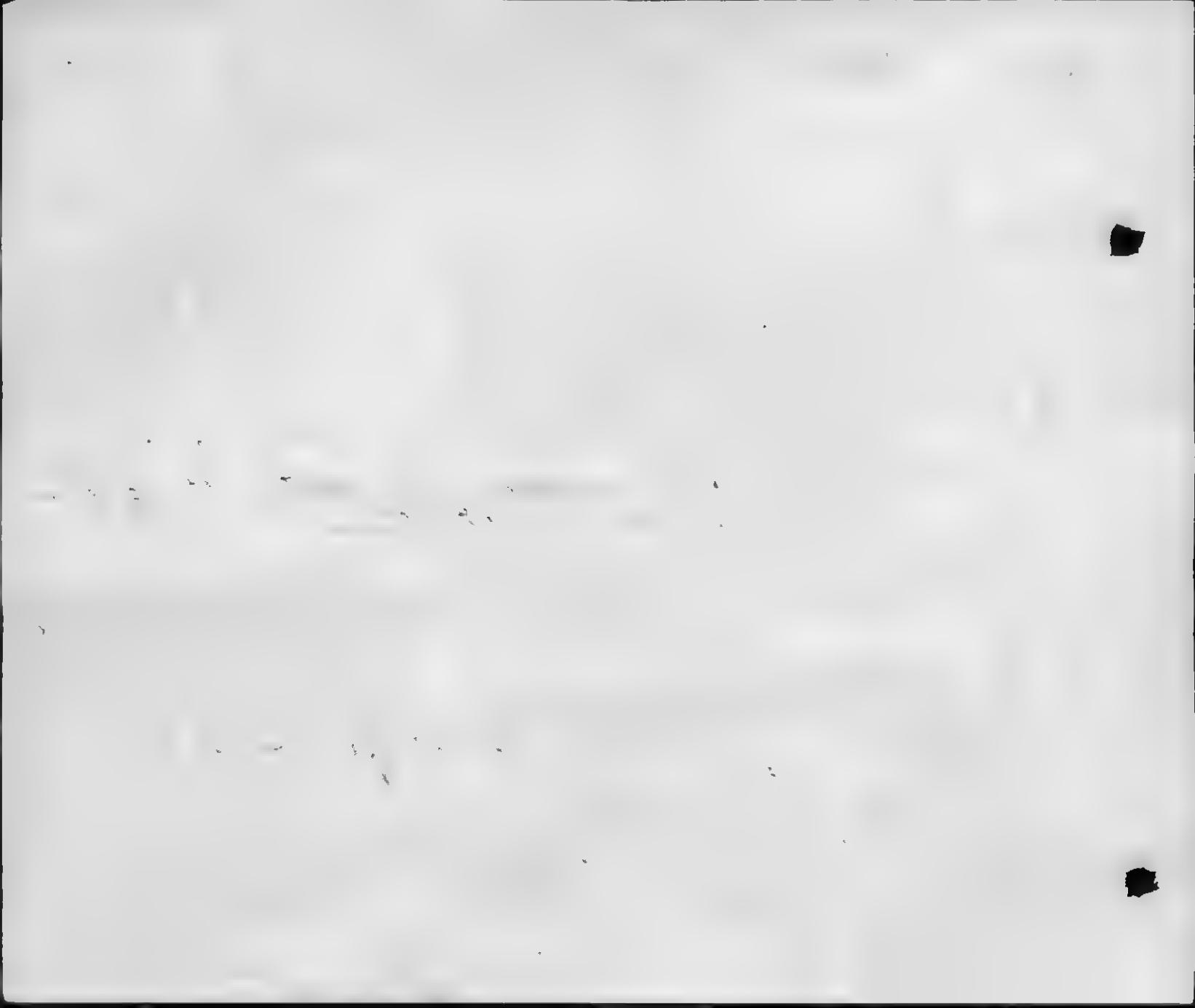
DUL 26 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

M

TO **STATE MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to **Funeral Director**. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

C352 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08346

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sunnybrook

d. STREET ADDRESS

5522 Volta Ave

e. IS RESIDENCE
ON A FARM?

YES NO

Year

19 61

3. NAME OF
DECEASED
(Type or print)

First
Arthur

Middle
Clifford

Last
Jones

4. DATE
OF
DEATH

Month
July

Day
27

Year

19 61

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

July 8, 1885

9. AGE (In years
last birthday)

7 3 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Gardner

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Govt

11. BIRTHPLACE (State or foreign country)

District of Columbia U.S.A.

13. FATHER'S NAME

Edward Jones

14. MOTHER'S MAIDEN NAME

Unknown

Address 5708 Beecher St

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Mrs Marjorie Rollins. Tuxedo, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

142

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Cerebrovascular Accident

INTERVAL BETWEEN
ONSET AND DEATH

DUE TO

(c)

Cardiovascular Renal Disease

19. WAS AUTOPSY PERFORMED? YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

7/28/61

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

James I. Boyd

Address (Street, city, town, or county)

22e. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State)

Burial 7-3-1961 Cedar Hill Wash.

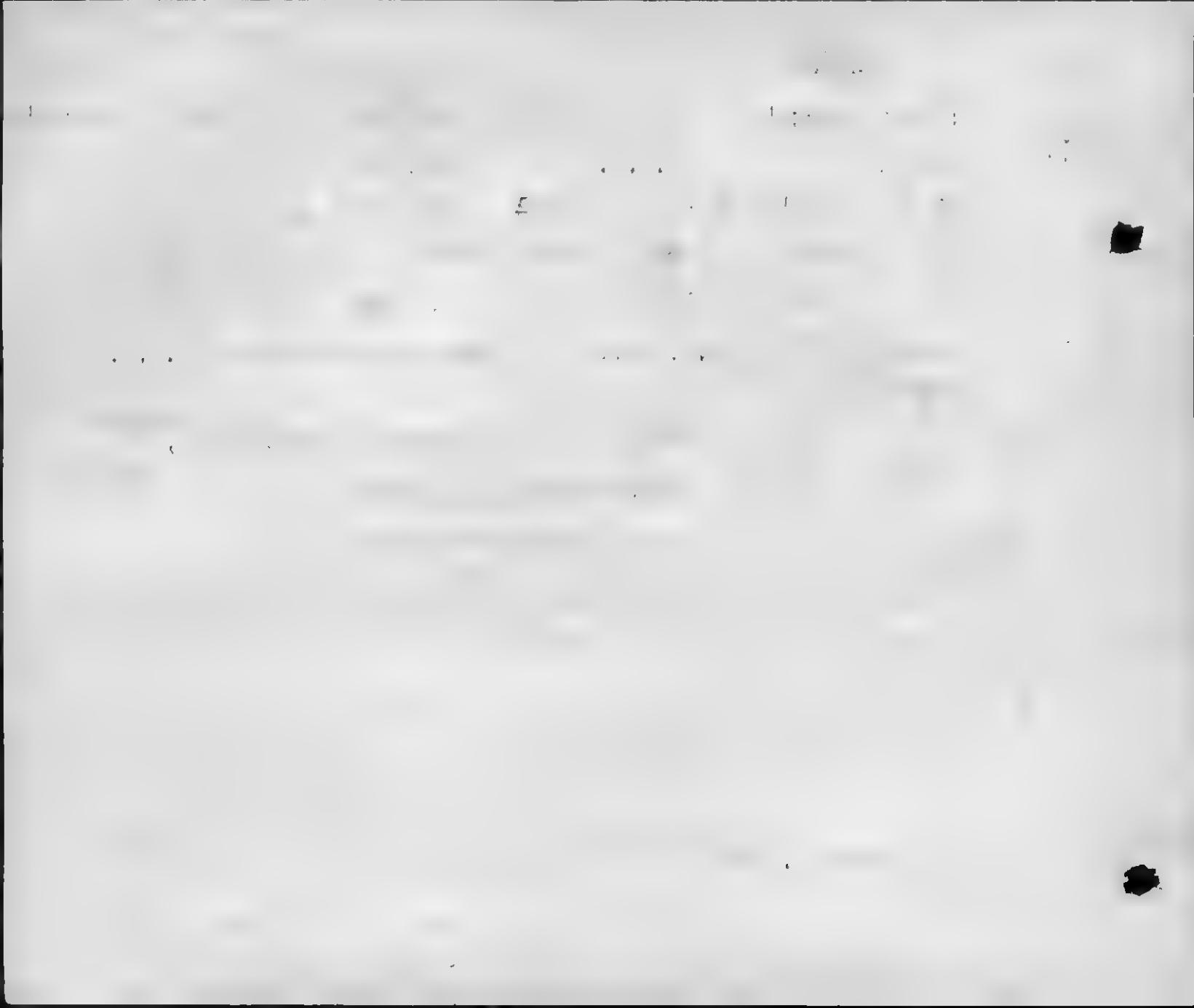
REC'D BY REGISTRAR

JUL 31 '61

DATE

23. FUNERAL DIRECTOR Robert A. Mattingly 131-11878 JUL 31 '61

Cirina S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

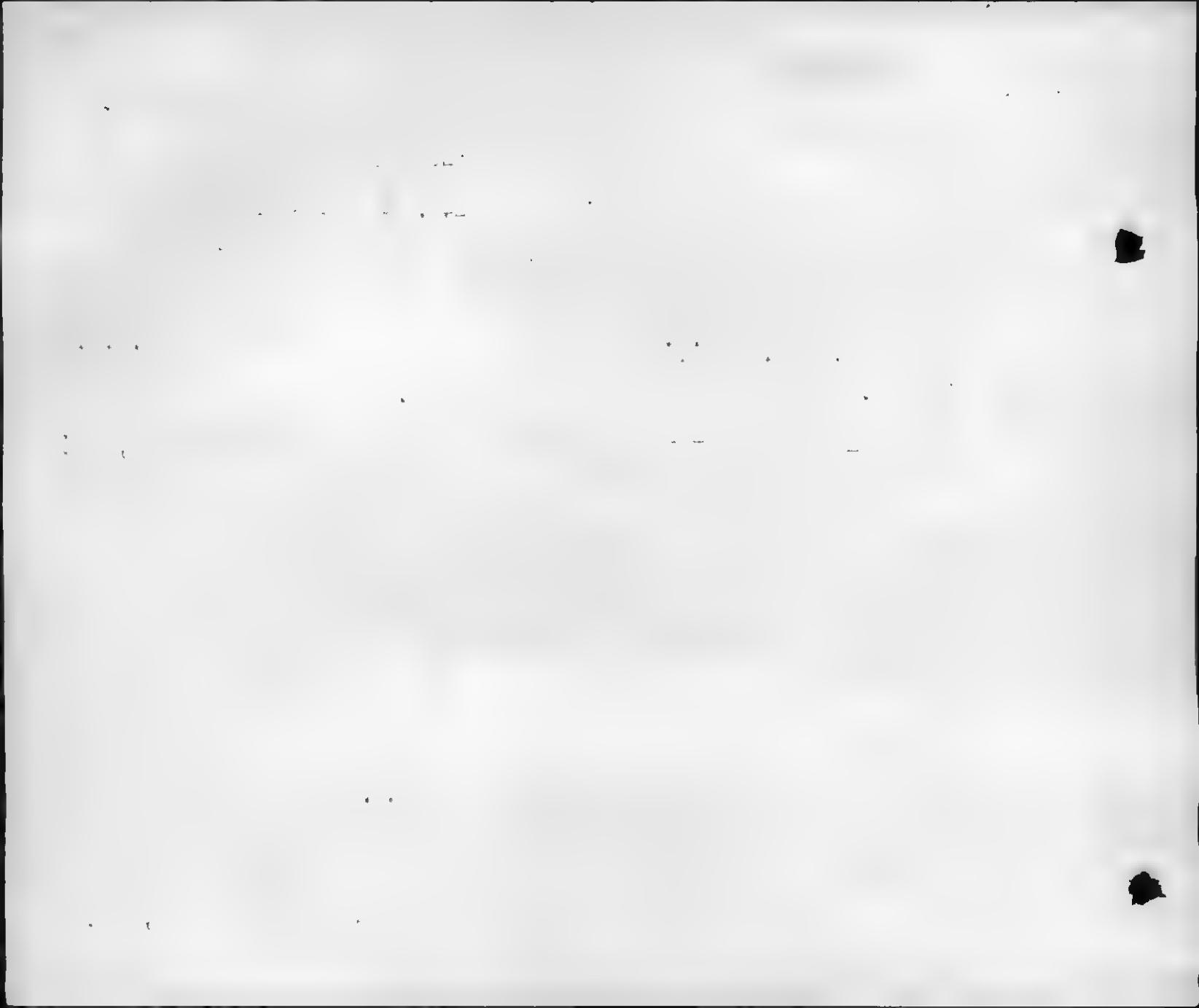
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08347

2353

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		d. STREET ADDRESS 7401 Tilden Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 8 days		d. STREET ADDRESS Belle Mead		e. DATE OF DEATH 7 / 3 / 61		f. MONTH July		g. DAY Wednesday		h. YEAR 1961			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. FIRST Howard		f. MIDDLE Jones		g. LAST		h. DATE OF BIRTH 5/5/89		i. AGE (in years last birthday) 72 yrs.		j. IF UNDER 1 YEAR Months 0 Days 0		k. IF UNDER 24 HRS Hours 0 Min. 0	
3. NAME OF DECEASED (Type or print)		4. SEX Male		5. COLOR OR RACE White		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/5/89		9. IF UNDER 1 YEAR Months 0 Days 0		10. IF UNDER 24 HRS Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Ass't. Div. Head. Revenue		10b. KIND OF BUSINESS OR INDUSTRY U.S. Internal Revenue		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME John H. Jones		14. MOTHER'S MAIDEN NAME Emma J. Billard													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Irene Bradley Jones		Address 7401 Tilden St. Belle Mead, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 160X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebrovascular Disease		INTERVAL BETWEEN ONSET AND DEATH									
PART II. DUE TO 160X		(b) DUE TO Arteriosclerotic heart Disease		Cerebrovascular Disease											
(c) DUE TO Diabetes mellitus															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) From loss of both legs.		20c. TIME OF INJURY Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 6:26, 1961, to 7:3, 1961		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 6:26, 1961, to 7:3, 1961 that (I) (we) last saw the deceased alive on 7:3, 1961 and that death occurred at 9:02A , from the causes and on the date stated above.		22a. SIGNATURE C. Deitz, M.D.		M.D.		ATTENDING PHYS. P.D.M.		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/7/61			
22c. PHYSICIAN'S NAME (Type) Joseph L. Johnson, Inc.		22d. ADDRESS 1756-Ba. Alto													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-7-1961		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery, Silver Spring, Md.		23d. LOCATION (City, town, or county) Wash D.C.		(State)							
24. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Johnson, Inc.		ADDRESS 1756-Ba. Alto		25a. REC'D BY REGISTRAR DATE JUL 7 '61		25b. REGISTRAR'S SIGNATURE C. Deitz, M.D.									



1
FOR STATE
HEALTH DEPT.

Please seal the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8354 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8343

1. PLACE OF DEATH

a. COUNTY

Prince George's

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hillcrest Heights

c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2411 Farley Place

MARYLAND

c. LENGTH OF STAY IN HB

1 year

3. NAME OF
DECEASED
(Type or print)

First

William

Middle

Theodore

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Examiner

10b. KIND OF BUSINESS OR INDUSTRY

Internal Revenue

13. FATHER'S NAME

William Warren Brockington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

Yes WW II

16. SOCIAL SECURITY NO.

577-26-0909

17. INFORMANT

Mildred Keen

Address

3007 Erie St., S.E. Wash., D.C.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Hemorrhage and shock

976X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

Gun shot wound in the head.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20c. TIME OF INJURY

Month, Day, Year

Hour XX
11:55 p.m.

7/14/61

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Self inflicted gun shot wound of the head.

20d. INJURY OCCURRED
While at work Not While at work

XX

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

(County)

(State)

Hillcrest Hts P.G.

Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

7/15/61

ACTUAL
SIGNATURE

James I. Boyd

Address (Street, city, town, or county)

NAME (Type)
REMOVAL (Specify)

Dr. James I. Boyd

(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

Burial

7.19.1961

Arlington National

Arlington, Virginia

23. FUNERAL DIRECTOR

ADDRESS

J. L. Lee 3004 1/2 NE Wash DC

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

JUL 20 '61

Arthur L. Kraus



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8355

CERTIFICATE OF DEATH

C8349

1. PLACE OF DEATH a. COUNTY Prince George's Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE DC.		b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradybury Park		c. LENGTH OF STAY IN lb 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC.		d. STREET ADDRESS 1438- 18th Street S.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2300- Gaylord Street S.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ANIE	Middle M.	Last KERIS	4. DATE OF DEATH July 26th 1961	Month July	Day 26	Year 61
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 25th 1890	9. AGE (In years last birthday) yrs 70	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Washington, DC.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Doyle		14. MOTHER'S MAIDEN NAME Mary Burns					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Charles P. Howard, 2007- Lakewood St. SE.		Address Wash., 23, DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4113 X Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last		Annie Cardiac dysfunction		INTERVAL BETWEEN ONSET AND DEATH 6 days			
DUE TO (b) DUE TO (c)		Hypertensive heart disease		20 yrs t			
		Hyperglycemia		20 yrs t			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1941 to July 26, 1961, that (I) (we) last saw the deceased alive on July 24, 1961, and that death occurred at 3:30 M. from the causes and on the date stated above							
22a. SIGNATURE James C. Cawood		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED July 26, 1961			
22d. PHYSICIAN'S NAME (Type) JAMES C. CAWOOD		22d. ADDRESS 2520- Pa. Ave., S. E. Washington, DC					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 28- 1961		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		1661- ADDRESS Washington DC		25a. REC'D BY REGISTRAR DATE JUL 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8356

08350

CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BURIAL DIRECTOR: After this certifcate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

1. PLACE OF DEATH

a. COUNTY

Prince George

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Riverdale

c. LENGTH OF STAY IN 1b

8 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Leland Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle Last

Vola May Kilby

5. SEX

6. COLOR OR RACE

Female White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife at home

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (County & State, or foreign country)

U.S.A. Balt. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Arnold unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give year or dates of service)

no

none Hospital Record

R. H. Kilby (Son)

INTERVAL BETWEEN ONSET AND DEATH

Sheek

Septicemia

Urinary Tract Infection

CHF, cystocele rectocele, goiter

19. WAS AUTOPSY PERFORMED?

YES NO

20c. TIME OF INJURY Month, Day, Year

Hour a.m. 20d. INJURY OCCURRED

p.m. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

White Not White

at work at work

21. I certify that (I) (this hospital) attended the deceased from July 4, 1961, to July 4, 1961, that (I) (we) last saw the deceased alive on July 4, 1961, and that death occurred at 11 P.M. from the causes and on the date stated above.

22e. SIGNATURE

R. H. Sandstrom

22c. PHYSICIAN'S NAME (Type)

R. H. Sandstrom

23e. DATE THEREOF

REMOVAL (Specify)

Burial

7-8-1961

Washngtn National

ADDRESS

5801 Cleveland Ave.

Riverdale, Md.

23d. LOCATION (City, town or county) (State)

Silver Spring, Maryland

25a. REC'D BY REGISTRAR

DATE JUL 10 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Haas

24 FUNERAL DIRECTOR'S SIGNATURE

W. W. Chambers Jr.

Riverdale, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8357

CERTIFICATE OF DEATH

38351

1
PLACE OF DEATH

a. COUNTY

Prince Georges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Riverdale

MARYLAND

c. LENGTH OF STAY IN 16

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Eugene Island Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Lottie

E.

Kimball

4. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

1-1-83

Last

4. DATE
OF
DEATH

Month

July

Day

22

Year

19 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Missouri

12. CITIZEN OF WHAT COUNTRY?

America

13. FATHER'S NAME

Barnes

14. MOTHER'S MAIDEN NAME

Eva Lina Moss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Hospital Records Riverdale, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN
ONSET AND DEATH

1 week

1 week

undetermined

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. 19 While at work20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) attended the deceased from July 22, 1961, to July 22, 1961, that (I) last saw the deceased alive on July 22, 1961, and that death occurred at 9 AM, from the causes and on the date stated above.

22a. SIGNATURE

L.W. Malin

M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

L.W. Malin M.D.

ATTENDING
PHYS.
22d. ADDRESSMED.
DIRECTOR
STAFF
PHYS.

7-22-61

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

Burial 7/25/61

23c. NAME OF CEMETERY OR CREMATORIAL

Ft. Lincoln

23d. LOCATION (City, town or county)

Colmar Manor,

(State)

Md.

24 FUNERAL DIRECTOR'S SIGNATURE

F. Gasch's Sons

ADDRESS

Hyattsville, Maryland

25a. REC'D BY REGISTRAR

DATE JUL 26 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8358

CERTIFICATE OF DEATH

C8352

Item 14 from birth cert 6/26/61

1. PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 5046 Dixon Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby		First Boy	Middle Kocher	4. DATE OF DEATH July	Month Day Year 31 19 61
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 16 July 1961	9. AGE (In years lost birthday) — yrs	IF UNDER 1 YEAR Months Days Hours Min 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Harrison Kocher		14. MOTHER'S MAIDEN NAME Patricia Jean Miller		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN J. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Harrison Kocher</i> DUE TO 762 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 15, 1961</i> to <i>July 31, 1961</i> , that (I) (we) last saw the deceased alive on <i>July 30, 1961</i> , and that death occurred at <i>6:15 AM</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>Harrison Kocher</i>		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>7/31/61</i>	
22c. PHYSICIAN'S NAME (Type) Dr. Parker, M.D.		22d. ADDRESS			
23a. BURIAL CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 8/3/61		23c. NAME OF CEMETERY OR CREMATORIAL Prince Geo. Gen. Hospital	
24. FUNERAL DIRECTOR'S SIGNATURE Marilyn W. Penn, Jr., Administrator		ADDRESS		23d. LOCATION (City, town, or county) Cheverly, Maryland	
				25a. REC'D BY REGISTRAR DATE AUG 8 '61	
				25b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8359

09353

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines Md		c. LENGTH OF STAY IN lb Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6314 Patterson Road		e. STREET ADDRESS 6314 Patterson St	
3. NAME OF DECEASED (Type or print) Katherine		First A.	Middle Kumm
4. DATE OF DEATH Dec 14, 1894		Month July	Day Year 27 1961
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) New York
13. FATHER'S NAME Joseph Seiler		14. MOTHER'S MAIDEN NAME Caroline Schube	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. --	17. INFORMANT Henry Kumm
			Address East Pines, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>from phos as come</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 24			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-15 , 1961, to July 27th , 1961, that (I) (we) last saw the deceased alive on July 27th , 1961, and that death occurred at 11:25 AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Vil Bergman Ann</i>		22b. DATE July 27, 1961	
22c. PHYSICIAN'S NAME (Type) Till BERGEMANN		22d. ADDRESS 534 Graceland Ave Greenbelt	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/31/61	
23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) Greenbelt (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE AUG 3 '61
			25b. REGISTRAR'S SIGNATURE <i>James J. Kraas</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3360

CERTIFICATE OF DEATH

08354

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 wks 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Clinton (Rural)		d. STREET ADDRESS Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Norman L. Lucas		First	Middle	Last	4. DATE OF DEATH July 27 1961	Month	Day	Year	
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH March 1893	9. AGE (in years last birthday) 68 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter--Retired		10b. KIND OF BUSINESS OR INDUSTRY General Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Ned Lucas				14. MOTHER'S MAIDEN NAME Betty Swann					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 578-18-4339		17. INFORMANT Clara E. Leonberger, 1905--17th St. S.E. Wash. DC		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
<i>c.v.a</i>									
INTERVAL BETWEEN ONSET AND DEATH									
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.									
(c) DUE TO <i>Castane Resection</i>									
(d) DUE TO <i>Renal de-Masses</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-8 1961</u> to <u>7-27 1961</u> , that (I) (we) last saw the deceased alive on <u>7-27 1961</u> , and that death occurred at <u>222 M</u> , from the causes and on the date stated above									
22a. SIGNATURE <i>A. Banisach</i>		M.D. ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>7.27.61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>P. G. C. H.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/29/1961		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Prince George's Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i>		ADDRESS <i>514 11th ST. S.E.</i>		25a. REC'D BY REGISTRAR DATE JUL 28 1961		25b. REGISTRAR'S SIGNATURE <i>Arthur J. Mann</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND													
8361				CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Prince George's									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 36 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. STREET ADDRESS 5725 - 43rd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital													
3. NAME OF DECEASED (Type or print) Charles		First E. Middle		Last Martin		4. DATE OF DEATH July 24 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13, 1886		9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Electrical				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles M. Martin				14. MOTHER'S MAIDEN NAME Laura Robey									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO 718-14-9097		17. INFORMANT Mrs. Mary Nippes		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
no						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Branch pneumonia RML & LLL Due to (b) <i>Care of the section</i> Due to (c)				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 2-4 1940 to 7-25 1961 , that (I) (we) last saw the deceased alive on 7-15 1961 , and that death occurred at 910M , from the causes and on the date stated above													
22a. SIGNATURE 				M.D.		ATTENDING PHYS. <input type="checkbox"/> M.D. <input type="checkbox"/> DIRECTOR		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Hyattsville, Md.			
22c. PHYSICIAN'S NAME (Type)													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/61		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		23d. LOCATION (City, town, or county)		(State) Colmar Manor, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE JUL 27 61		25b. REGISTRAR'S SIGNATURE Arthur S. Thrall			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8362

89356

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Prince George's

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

MARYLAND

c. LENGTH OF STAY IN 1b

15 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

George

C.

Martin

4. SEX

6. COLOR OR RACE

Male

White

WIDOWED

DIVORCED

10e. USAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE County & State, or foreign country

Ret. Steamfitter

Self

3/22/88

13. FATHER'S NAME

George C. Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give rank or dates of service]

Yes WW 1

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Myrtle M. Martin Same as # 2 (Wife)

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

multiple Pulmonary infarcts

INTERVAL BETWEEN
ONSET AND DEATH

3 days

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

Thrombo phlebitis, LEFT Femoral 7 days

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

aerembol Thrombosis right

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on... and that death occurred at from the causes and on the date stated above.6/27 1961 to 7/11 1961
PM

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial23b. DATE THEREOF
7/14/61

23c. NAME OF CEMETERY OR CEM. CO.

Ft. Lincoln

ATTENDING
PHYS.

22d. ADDRESS

MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

7/11/61

24 FUNERAL DIRECTOR'S SIGNATURE

Francis Gasch's Sons

ADDRESS

Hyattsville, Md.

25e. REC'D BY REGISTRAR
DATE JUL 14 '6125b. REGISTRAR'S SIGNATURE
Charles S. Flanagan

١٣٦ نجف و مکانات

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

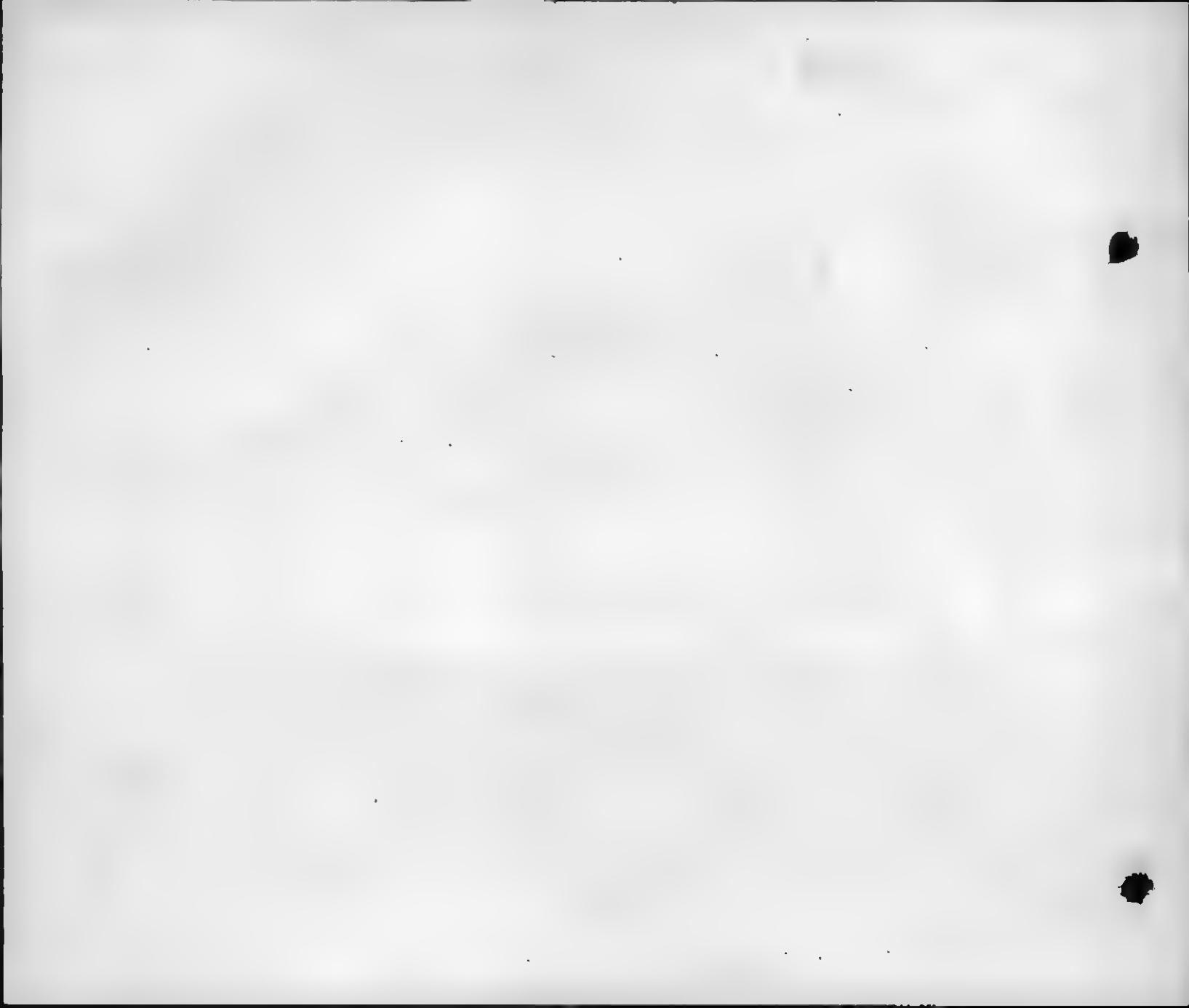
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8363

CERTIFICATE OF DEATH

88357

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Columbia Park		d. STREET ADDRESS 2608 Ohio Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Adolph	Middle P.	Last Mattia	4. DATE OF DEATH July 24 1961	Month July	Day 24	Year 1961
S SEX Male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH March 28, 1902	9 AGE (In years last birthday) 59 yrs	11 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a JSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b KIND OF BUSINESS OR INDUSTRY Office Machines		11 BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Sylvia Mattia				14. MOTHER'S MAIDEN NAME Nicolnia Santalli			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-05-5925		17. INFORMANT Esther I. Mattia Same as # 2 (Wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 57 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO Bronchopneumonia DUE TO Portal Cirrhosis. DUE TO 3 days 14 years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? NO							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6 - 26 - 1961 to 7 - 24 - 1961 , that (I) (we) last saw the deceased alive on 7 - 24 - 1961 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Waldo B. Moyers				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Waldo B. Moyers				22d. ADDRESS 3803 Perry St. Mt. Rainier Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/61		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 27 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Krause	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

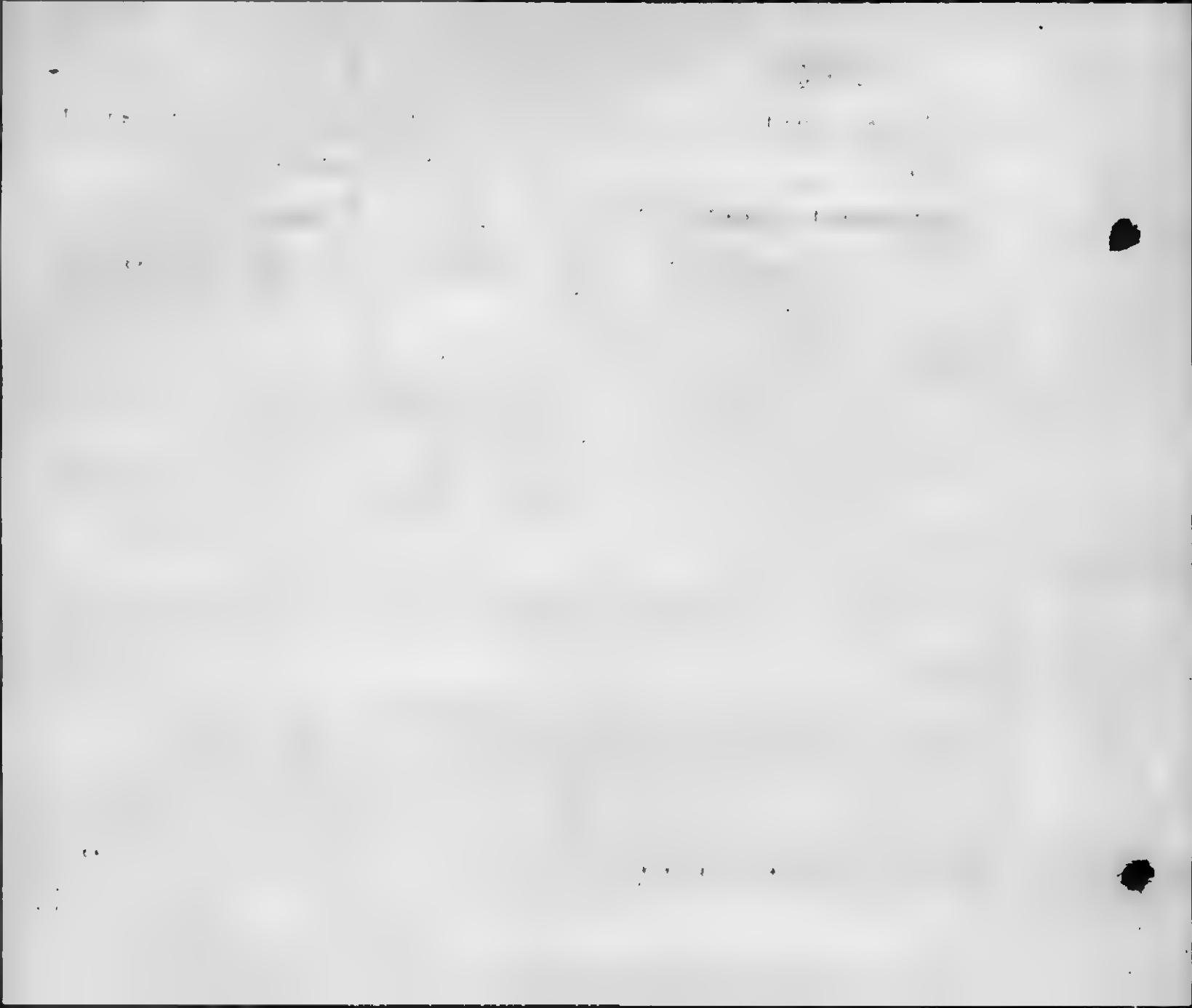
8364 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08359

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1102 61 st Avenue	
3. NAME OF DECEASED (Type or print) First Middle		4. DATE OF DEATH McLean July 13th., 1961	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME unknown		11. BIRTHPLACE (State or foreign country) unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT unknown		14. MOTHER'S MAIDEN NAME unknown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5764		DUE TO Perforated duodenal ulcer	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Genesleal peritonitis		(b) DUE TO unknown	
(c) DUE TO unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE SIGNED July 14th., 1961	
22b. DATE THEREOF 8-1-61		22c. NAME OF CEMETERY OR CREMATORIUM V of Md. Med School	
23. FUNERAL DIRECTOR Johnston		22d. LOCATION (City, town, or county) Baltimore Md	
ADDRESS		24e. REC'D BY REGISTRAR AUG 2 '61	
		24f. REGISTRAR'S SIGNATURE Wilma L. Thane	

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If it is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8365

8359

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Prince George

b. CITY OR TOWN (if outside a corporate limit, write RURAL and give nearest town)

Cheverly

MARYLAND

c. LENGTH OF STAY IN 1b

4 Days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF

DECEASED
(Type or print)

Mamie

First

Middle

A

Messina

4. SEX

6. COLOR OR RACE

Female White

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

own home

13. FATHER'S NAME

Henry A. Applebaum

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

579 44 9986 Mary M Steninger

Address

Cheverly, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a).

11
 DUE TO
 Conditions, if any, which
 gave rise to immediate cause
 (b), stating the underlying
 cause last.
 DUE TO
 (c)

Bronchopneumonia PHLEBOL.

Arteriosclerosis 1st di.

Cerebral thrombosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

Diabetes Mellitus -

INTERVAL BETWEEN
ONSET AND DEATH20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from June 1960 to July 8, 1961, that (I) (we) last saw the deceased alive on July 8, 1961, and that death occurred at 10A.M. from the causes and on the date stated above.

22a. SIGNATURE

William Rosson, M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

7/8/61 DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Dr. William Rosson, M.D.

22d. ADDRESS

5701 85th Ave, Hyattsville, Md.

23a. BURIAL, CREMATION

23b. DATE THEREOF

Burial (Specify) July 11, 1961

23c. NAME OF CEMETERY OR CREMATORIUM

Mt Olivet Cemetery

23d. LOCATION (City, town or county)

Washington, D.C.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

F. Gasch's Sons

ADDRESS

Hyattsville, Md.

25a. REC'D BY REGISTRAR

DATE JUL 13 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M I 2

VR A15 (4)
15M 9/60

CHONAKTA

2414 8712

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8365

CERTIFICATE OF DEATH

08365

1. PLACE OF DEATH

e. COUNTY

Prince George
Laurel

MARYLAND

c. LENGTH OF STAY IN TB

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

379 Main Street

3. NAME OF
DECEASED
(Type or print)

First

Middle

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

10b. KIND OF BUSINESS OR INDUSTRY

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)420.50 DUE TO
Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause last.(b) DUE TO
Cerebral Hypertension
Hypertensive Cardio - Vasculare Disease(c) DUE TO
Cerebro - Vascular Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?
YES NO 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 White Not White
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (the hospital) attended the deceased from... 1957 19 , July 8 , 1961 , that (I) (we) last

saw the deceased alive on July 8 , 1961 , and that death occurred 3:30 P.M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

ROBERT C. KINGFIELD

23a. BURIAL, CREMATION, DATE THEREOF
REMAINS (Specify)

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)
(State)

Burial July 12, 1961 Ft. Lincoln Cemetery, Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

De Witt Danaldean, Laurel, Md.

25a. REC'D. BY REGISTRAR JUL 13 1961

25b. REGISTRAR'S SIGNATURE Arthur S. Turner

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

X

I

C

Y

Z

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8367

CERTIFICATE OF DEATH

08361

1. PLACE OF DEATH

a. COUNTY

Prince Georges

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

(Rural) Glenn Dale

MARYLAND

c. LENGTH OF STAY IN TB

1 mo. 20 das.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Glenn Dale Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Hiram

Albert

Minor

5. SEX

6. COLOR OR RACE

Male

Negro

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

July 16, 1882

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

unknown

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Waterford, Va.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Daniel Webster Minor

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

none

Person

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

carcinoma of the right lung
Histologic type unknownConditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Hepatitis, etiology undetermined

INTERVAL BETWEEN
ONSET AND DEATH

approx 7 mo.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
Whiia Not Whiia
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from May 18, 1961, to July 8, 1961, that (I) (we) last saw the deceased alive on July 8, 1961, and that death occurred at 12:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Moe Weiss

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED
July 8, 196122c. PHYSICIAN'S
NAME (Type)

Moe Weiss, M.D.

22d. ADDRESS

Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

burial 7/11/61

23c. NAME OF CEMETERY OR CREMATORIAL

Hamilton

23d. LOCATION (City, town or county)

(State)

Loudoun Co.

Va.

24. FUNERAL DIRECTOR'S SIGNATURE

Brookwood

ADDRESS

#7358
Rockville Md.

25a. REC'D BY REGISTRAR

DATE JUL 11 '61

25b. REGISTRAR'S SIGNATURE

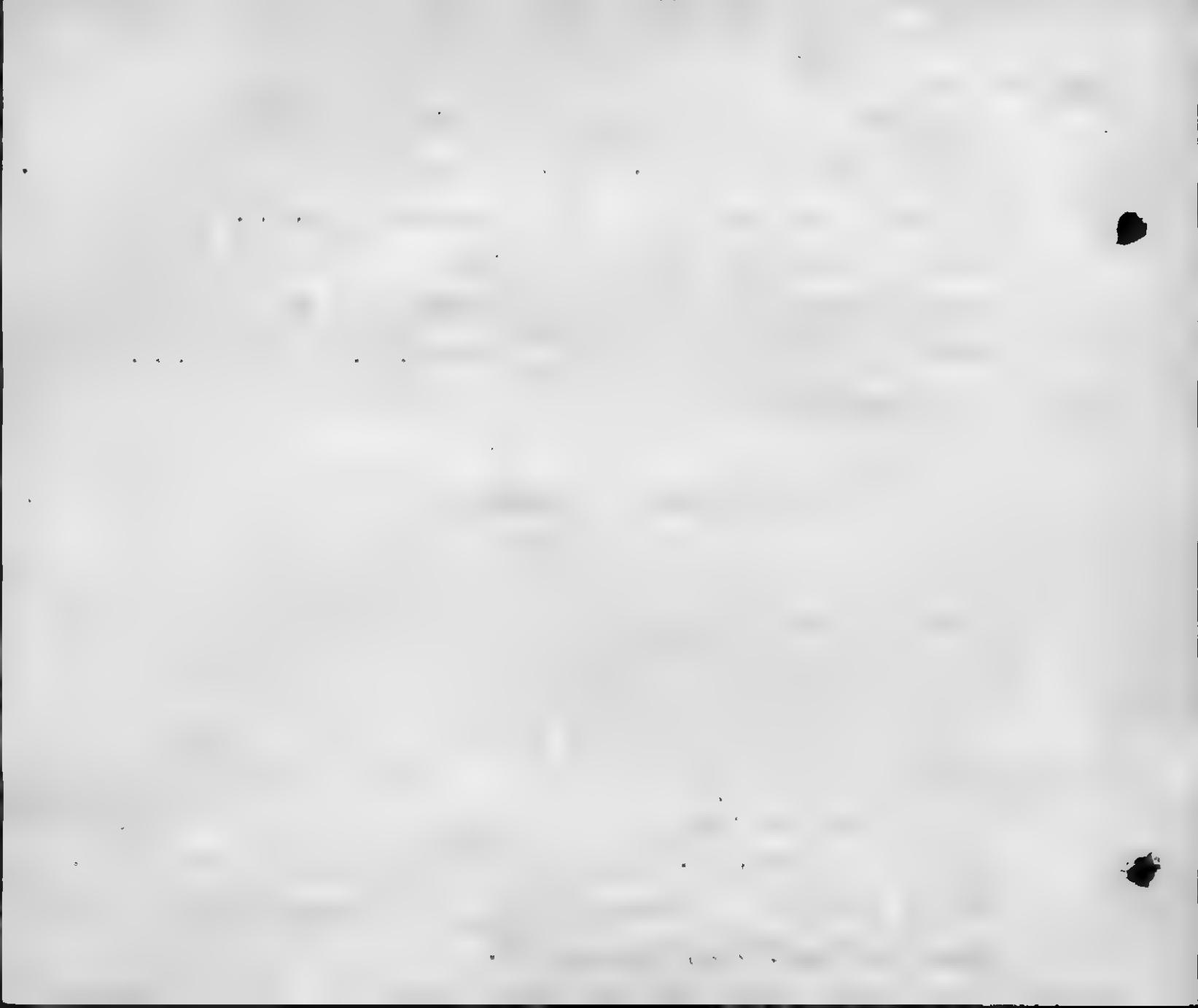
John S. Haas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M I

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
death. Age 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

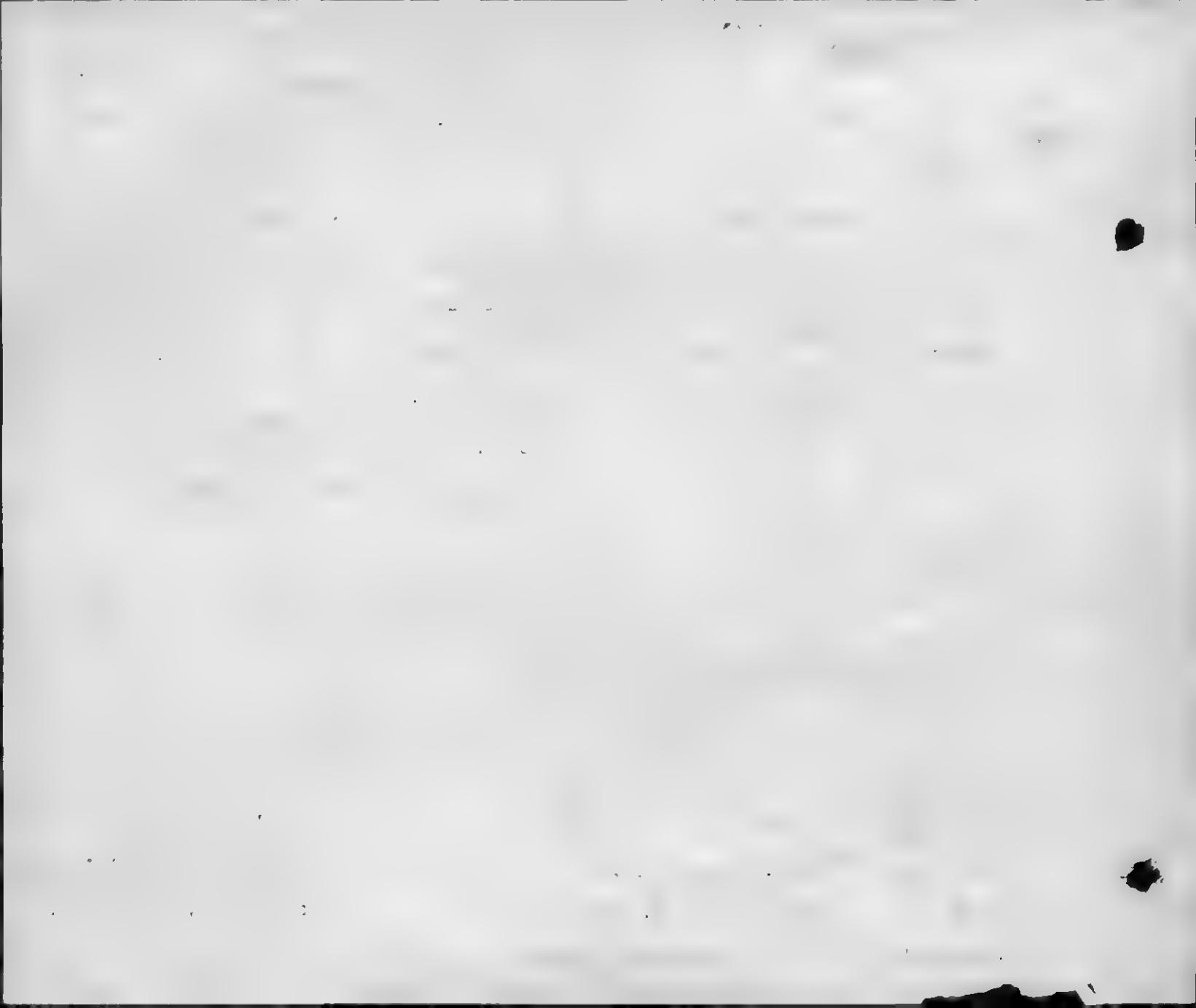
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8368

38362

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George	
c. LENGTH OF STAY IN 1b 12 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General		d. STREET ADDRESS 4806 52nd Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Eldridge	Middle W.	4. DATE OF DEATH Month July 15 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12-10-15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Store	
11. BIRTHPLACE County & State or foreign country Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Eldridge S. Morris		14. MOTHER'S MAIDEN NAME Lillie N. Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Ethel N. Morris	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) } DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 4806 52nd Ave. Hyattsville, Md.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 14, 1961 to July 15, 1961, that (I) (we) last saw the deceased alive on July 15, 1961, and that death occurred at 9:30 AM. The causes and on the date stated above.			
22e. SIGNATURE <i>William D. Rosson, M.D.</i>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 5/701 85th Avenue, Carrollton, Md.
22c. PHYSICIAN'S NAME (Type) William D. Rosson, M.D.	22d. ADDRESS Ft. Lincoln	23d. LOCATION (City, town or county) (State) Colmar Manor, Md.	
23e. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/18/61	23c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln	25e. REC'D BY REGISTRAR DATE JUL 18 '61
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	
ADDRESS Hyattsville, Maryland			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8369

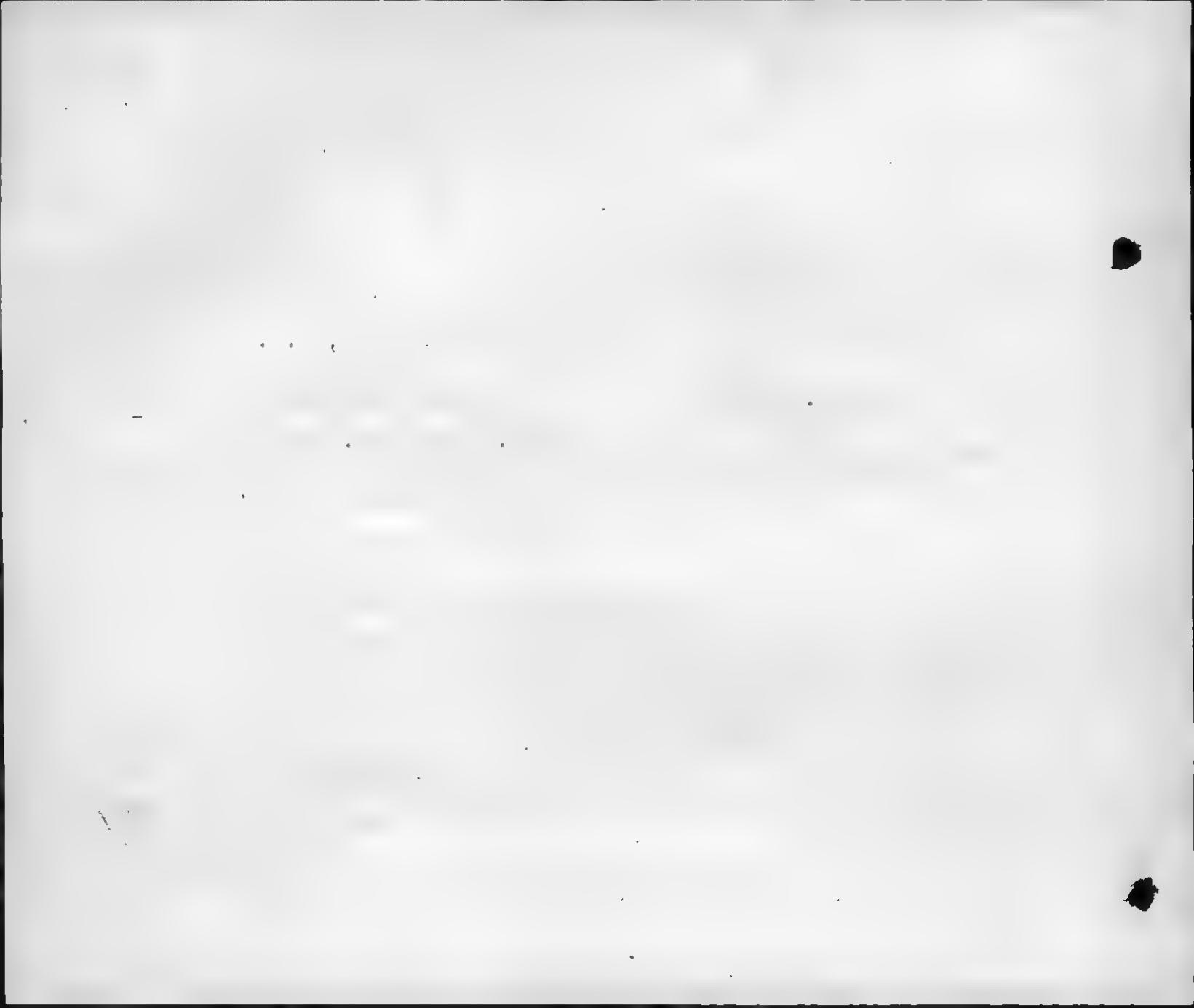
CERTIFICATE OF DEATH

38363

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Florence	Middle J	Last Mow
4. DATE OF DEATH	Month July	Day 1	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Feb 1889
9. AGE (In years last birthday) 72 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (State or foreign country) Washington, D.C.	12. CITIZEN OF WHAT COUNTRY? Address 5804-24th Pl.
13. FATHER'S NAME Andrew E. Gray		14. MOTHER'S MAIDEN NAME Josephine Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Dorothy F. Williams	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>loss of left ventricle</i> (c) <i>Arterio scl. H. d.</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (<u>this hospital</u>) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred <u>5:55 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <i>William D. Lessontree</i>		22b. DATE SIGNED <u>7/1/61</u>	
22c. PHYSICIAN'S NAME (Type) Dr. L. D. Lessontree		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial July 3 1961</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Cem.</i>	
23b. DATE THEREOF <i>July 3 1961</i>		23d. LOCATION (City, town or county) (State) <i>Arlington, Va.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home Wash. D.C.</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 5 '61</i>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Laura S. Kraus</i>	

ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be signed by the attending physician and completely retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.



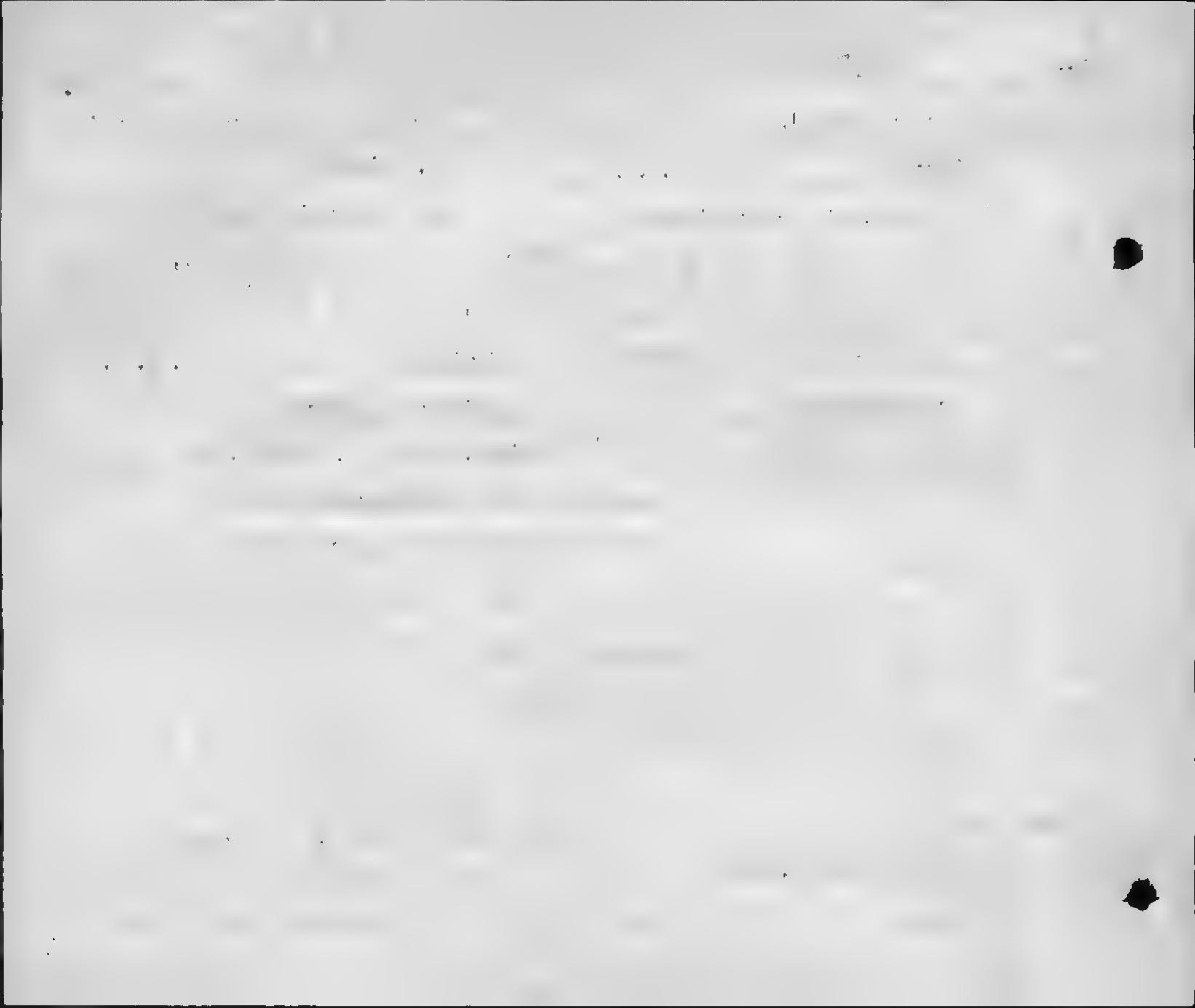
1
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
4
TO FUNERAL DIRECTOR: Please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08364

1. PLACE OF DEATH a. COUNTY Prince George's	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	b. COUNTY Prince George's				
c. LENGTH OF STAY IN MD D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital	d. STREET ADDRESS 3605 Bunker Hill Road				
3. NAME OF DECEASED (Type or print) Robert Dalton Moyer	4. DATE OF DEATH Last Month Day Year July 7, 1961				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH June 5, 1922		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector Airforce	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Virginia	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Dey	IF UNDER 24 HRS. Hours Min.
13. FATHER'S NAME Arthur Dalton	14. MOTHER'S MAIDEN NAME Julia Marie Edwards	12. CITIZEN OF WHAT COUNTRY? U. S. A.	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or dates of service) Yes WWI	16. SOCIAL SECURITY NO. 223-14-1930	17. INFORMANT Louis A. Moyer Mt. Rainier, Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			Acute congestive heart disease failure		
DUE TO (c)			Coronary arteriosclerotic heart disease		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd	CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7/7/61
EXAMINER'S NAME (Type) James I. Boyd	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-11-61	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National Cemetery, Arlington, Virginia	22d. LOCATION (City, town, or county) Arlington, Virginia	(State)	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.	24a. REC'D BY REGISTRAR DATE JUL 10 '61	24b. REGISTRAR'S SIGNATURE John S. Tracy			



14

FOR STATE
HEALTH DEPT.

M

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If it is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8371

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08365

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

Dead on arrival

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Sarah

Frances

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Fairmont Heights

d. STREET ADDRESS

603 60th Place

Last

Month

Day

Year

5. SEX

6. COLOR OR RACE

Female

Colored

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

Nov. 10, 1888

9. AGE (In years
last birthday)

72

IF UNDER 1 YEAR
Months DaysIF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife Ret.

10b. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Hillary Jackson

14. MOTHER'S MAIDEN NAME

Sarah (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank and dates of service)

No

None

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Frank H. Nash,

Address

603 60th Place

Fairmont Heights, Md.

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Toxemia and exhaustion

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

Lobar pneumonia, lung abscess and empyema

DUE TO

(c)

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

July 19th., 1961

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR

ADDRESS

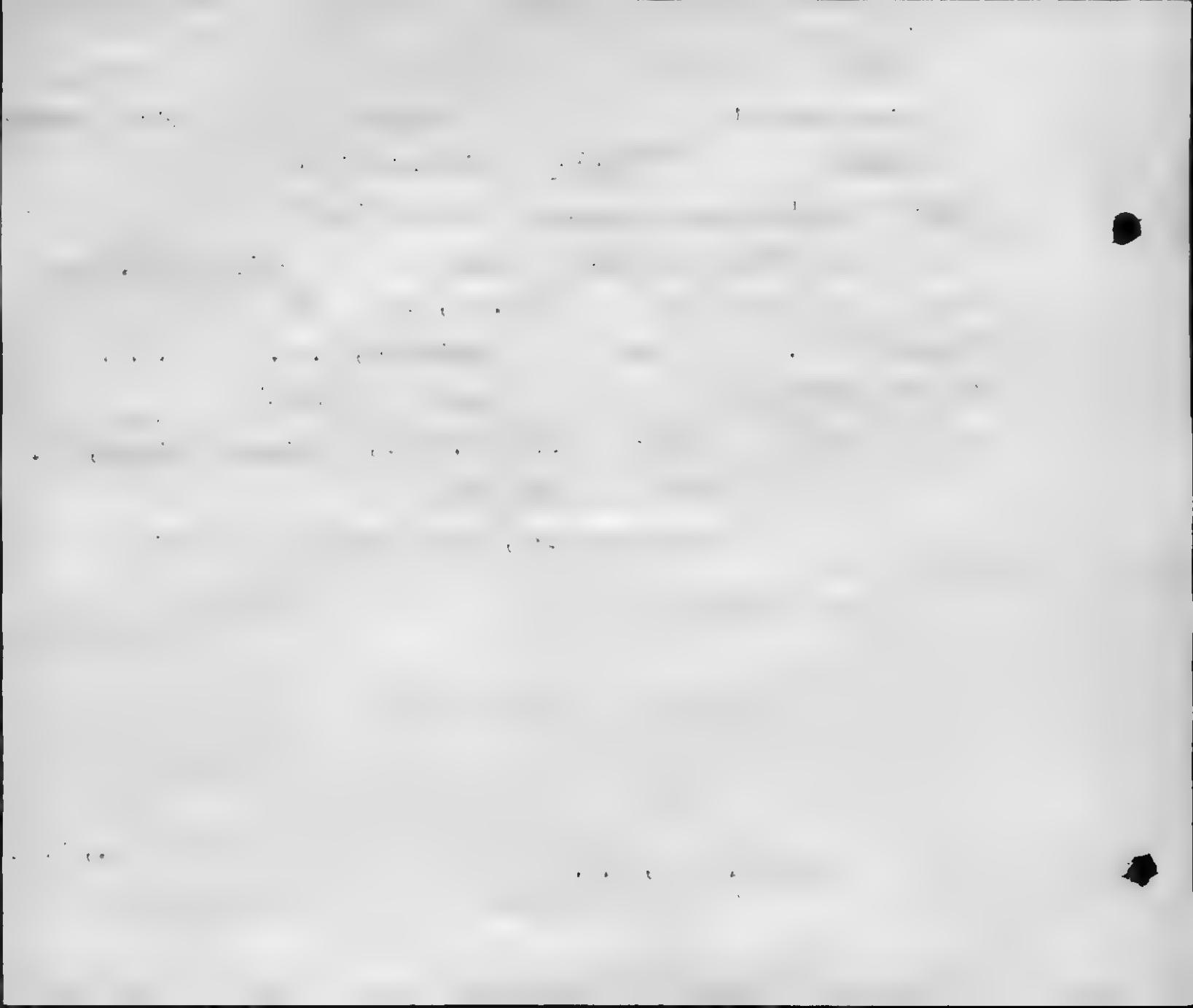
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

John T. Rhodes & Co.

DATE JUL 25 '61

Arthur G. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8372

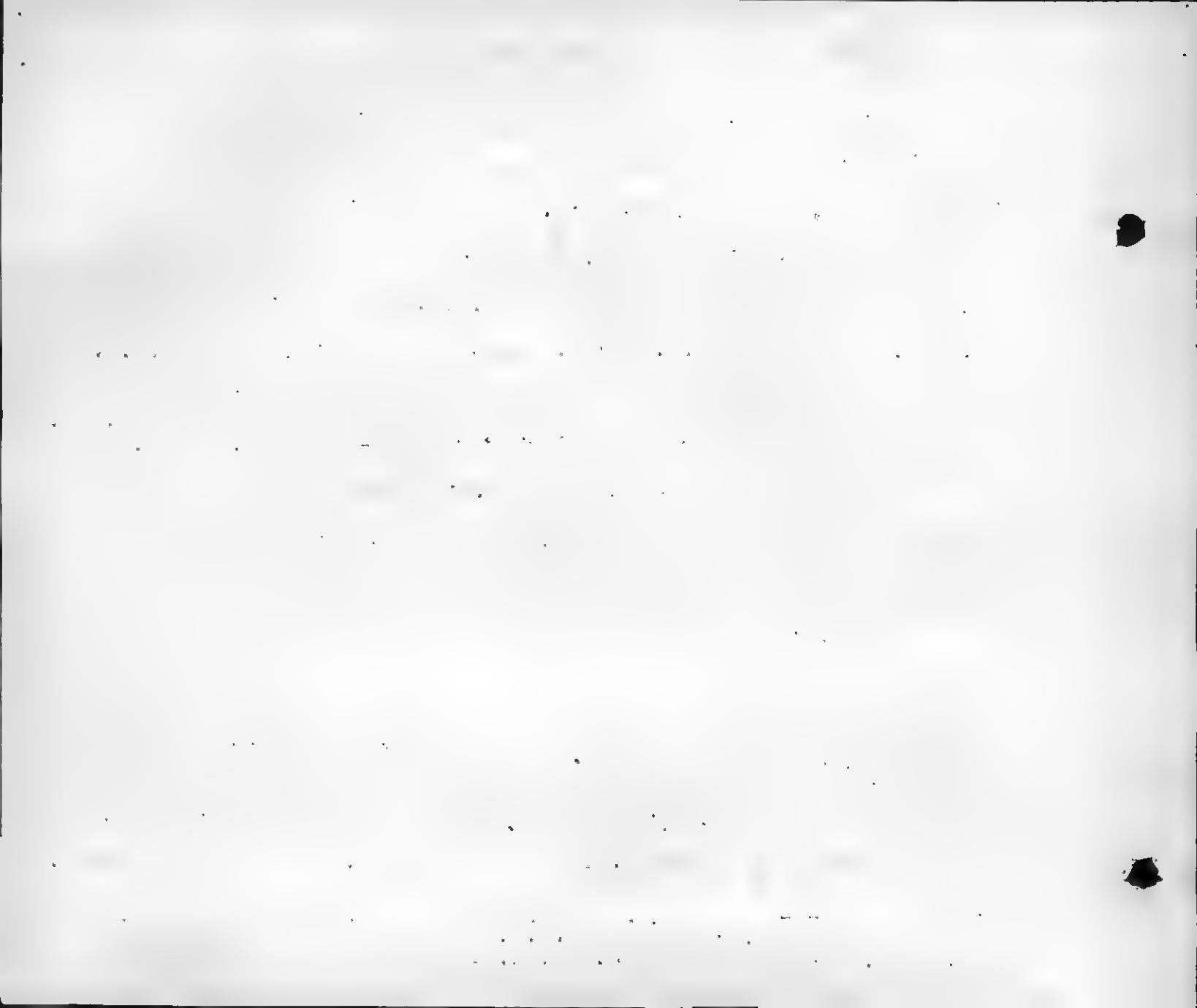
CERTIFICATE OF DEATH

Reg. Dist. No. 98366

PLACE OF DEATH a. COUNTY PRINCE GEORGE'S		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE NEW JERSEY		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) YACONVILLE		c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ATLANTIC CITY		d. STREET ADDRESS ALSHARKE HOTEL		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR, 4922 La SALLE, RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle I.	Last O'BRIEN	4. DATE OF DEATH JULY 30, 1961	Month JULY	Day 30	Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH SEPT. 19, 1877	9. AGE (In years last birthday) 83	10. IF UNDER 1 YEAR Months 83 yrs.	11. IF UNDER 24 HRS Days 83 hrs.	12. IF UNDER 24 HRS Hours 83 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY J.S. ACV'T.		11. BIRTHPLACE (State or foreign country) NEW YORK, NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME MORGAN O'BRIEN		14. MOTHER'S MAIDEN NAME -----						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. NO		INFORMANT SISTER PATRICK-4922 LaSalle Rd.		Address HYATTS. MD.		
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and, (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Central vascular accident (c) 2.1s. DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Infection INTERVAL BETWEEN ONSET AND DEATH								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 7/22, 1961, to 7/30, 1961, that I last saw the deceased alive on 7/22, 1961, and that death occurred at 3:45 AM, from the causes and on the date stated above.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) WASHINGTON, D.C.	(County) DISTRICT OF COLUMBIA	(State) D.C.
21. I certify that I attended the deceased from 7/22, 1961, to 7/30, 1961 , that I last saw the deceased alive on 7/22, 1961 , and that death occurred at 3:45 AM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) STEVEN ORISTIAN, M.D. 1534 16th Street, N.W. Washington, D.C.								
DATE SIGNED 7/22/61								
ACTUAL SIGNATURE Steven Oristan, M.D.								
PHYSICIAN'S NAME (Type) STEVEN ORISTIAN, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-1-61	22c. NAME OF CEMETERY OR CREMATORIAL St. OLIVER CATH. CHURCH			22d. LOCATION (City, town, or county) WASHINGTON, D.C.		(State) D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Hollings		ADDRESS FRANCIS J. COLLINS 3821 14th St. N.W.			24a. REC'D BY REGISTRAR AUG 2 '61	24b. REGISTRAR'S SIGNATURE Arthur J. Knapp		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, panel 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8373

CERTIFICATE OF DEATH

98367

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
Prince George's Maryland		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) House		c. LENGTH OF STAY IN 1b 3 yrs. 9 mo. 9 da	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp. list, give street address) Laurel Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH July 30 1961	
Martha Mary O'Brien		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years Mo. & day) Dec. 23, 1868 96 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State or foreign country) Prince Georges, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edwin Sullivan	
14. MOTHER'S MAIDEN NAME Mary A. Barnett		15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or date of serv.)	
17. INFORMANT Son - J.W. O'Brien - 1101 Montgomery		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arterio Sclerotic Heart Disease	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-25-58 to 7-30-61, that (I) (we) last saw the deceased alive on 7-29-61, and that death occurred at 7:30 P.M. from the causes and on the date stated above.		22a. SIGNATURE Jesse C. Coggins M.D.	
22c. PHYSICIAN'S NAME (Type) Jesse C. Coggins		22b. DATE SIGNED 7-30-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 1, 1961		23b. DATE THEREOF Aug 1, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery		23d. LOCATION (City, town or county) Laurel Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John McDonald, Funeral Director		25a. REC'D BY REGISTRAR AUG 4 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8374

CERTIFICATE OF DEATH

28363

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Prince George's MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George's	
c. LENGTH OF STAY N/A		c. CITY OR TOWN (if outsd'a corporata limits, write RURAL and give nearest town) Carrollton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's Gen. Hospital		d. STREET ADDRESS 8400 Sprague Pl.,	
First Middle Last		4. DATE OF DEATH July 23 1961	
3. NAME OF DECEASED (Type or print) Maureen Jane O'Connor		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 23 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		9. AGE (In years at last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Md.	
13. FATHER'S NAME Michael Joseph O'Connor		14. MOTHER'S MAIDEN NAME Maureen Jane Maguire	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT None Mother	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		C.N.S. Compression Hydrocephalus (Developmental)	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) X DUE TO Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from to on and that death occurred at M, from the causes and on the date stated above.		22e. SIGNATURE William R. Greco	
22c. PHYSICIAN'S NAME (Type) William R. Greco		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS	
23e. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 7/25/61	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet		23d. LOCATION (City, town or county) Washington D.C. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE JUL 27 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8375 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C2363

1. PLACE OF DEATH
a. COUNTYPrince George's MARYLAND
Camp Springs | c. LENGTH OF STAY IN lb
(9 yearsb. CITY OR TOWN (if outside corporate limits,
give PLATE and give nearest town)
Camp Springs

c. LENGTH OF STAY IN lb

9 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

5100 Ludlow Road Drive

3. NAME OF
DECEASED
(Type or print)

First Sophie

Middle Theresa

Last Paolo

4. DATE
OF
DEATH

Month July

Day 24

Year 61
19

5. SEX

6. COLOR OR RACE

Female White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

July 23, 1917

9. AGE (In years
less/birthday) yrs

IF UNDER 1 YEAR Months

IF UNDER 24 HRS
Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Hitzcynke

14. MOTHER'S MAIDEN NAME

Martyneck

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) If yes give rank or grade of service

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

Matthew Paolo, same as no 2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

POISONING

971.8
Conditions, if any, which
gave rise to immediate cause
(b), stating the underlying
cause last.
} DUE TO
} (c)

NICOTINE SULFATE

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, e.g.,

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
TOOK some black leaf 4020c. TIME OF INJURY
Month, Day, Year
7:50 AM 7/24/6120d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
Home20f. (City or town)
Camp Springs

(County)

(State)

P.G.

Md

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DATE SIGNED
7/24/61ACTUAL
SIGNATURE

James A. Boyd

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

(State)

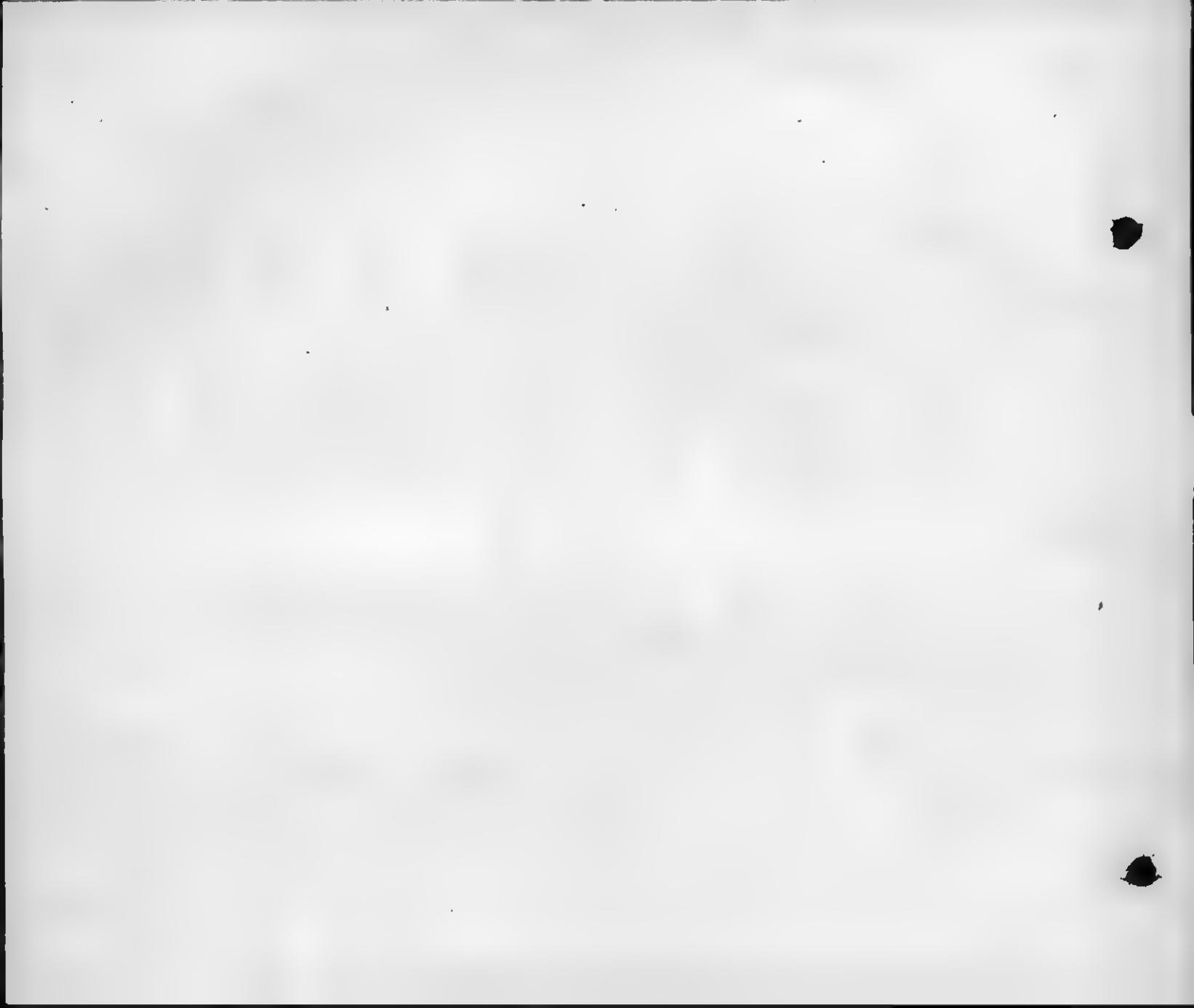
Albert S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
8376		38370									
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE									
Prince George MARYLAND		MINNESOTA Hennepin									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
SUITLAND		Minneapolis 6 th									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS									
SUITLAND NURSING HOME		515-9 th Ave. S.E.									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Lucy E. Pemberton					July	9	1961				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS				
Female		White		8-26-1880		80 yrs	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife		Domestic		MINNESOTA		U.S.A					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
JERRY FINNEY		MARY ANN PLUMMER									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No				Mrs. Virginia P. Norrgorden		166 - Chesapeake ST					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		15 days									
425-00		Congestive Heart Failure									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		15 days									
{		Right Hemiparesis									
(b)		Arterio - Thrombotic Heart Disease + Cerebral									
{		A.S.									
DUE TO		1 year									
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from August 16, 1961, to July 9, 1961, that (I) (we) last saw the deceased alive on 6/30 1961, and that death occurred at M, from the causes and on the date stated above.											
22a. SIGNATURE		22b. DATE SIGNED									
Anna Coyne Todd, M.D.		7/9/61									
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS									
		7519 Broadview Rd S.E.									
23a. BURIAL CEMETERY, 23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL									
Burial 7-11-61		Lakewood Cemetery Minneapolis, Minn.									
24. FUNERAL DIRECTOR'S SIGNATURE		25a. ADDRESS									
Simmons Bros. 1661 - Cedar Ridge Rd SE		25b. REG'D BY REGISTRAR									
		DATE JUL 13 '61									
		25c. REGISTRAR'S SIGNATURE									
		Arthur S. Traas									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8377

CERTIFICATE OF DEATH

88371

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 21 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) e. STATE DISTRICT OF COLUMBIA		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON		g. STREET ADDRESS 1000 MISSISSIPPI AVENUE SE		h. IF UNDER 1 YEAR — yrs. 21 Months 0 Dey 24 Hours 19 Min. 61	
3. NAME OF DECEASED (Type or print) RHONDA		First RHONDA		Middle LYNN		4. DATE OF DEATH JULY 3 1961		5. AGE (In years last birthday) — yrs. 21 Months 0 Dey 24 Hours 19 Min. 61	
6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 JULY 1961		9. IF UNDER 24 HRS. Address			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES			
13. FATHER'S NAME RAUL PEREZ		14. MOTHER'S MAIDEN NAME BRENDA KAY FANN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEDICAL RECORDS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TOXEMIA DUE TO Conditions, 75% (b) which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
						PNEUMONIA, EMPYEMA, PERITONITIS			
						TRACHEO-ESOPHAGEAL FISTULA REPAIR			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year p.m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
								(City or town) 1961 (County) 1961 (State) 1961	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3 JULY 1961 to 24 JULY 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 24 JULY 1961 , and that death occurred at 6: P.M. from the causes and on the date stated above.		22a. SIGNATURE <i>Edward G. Dowds</i>		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) EDWARD G. DOWDS, Captain USAF MC		22d. ADDRESS USAF HOSPITAL, ANDREWS AFB, MARYLAND		22e. DATE SIGNED 24 JULY 61					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/29/61		23c. NAME OF CEMETERY OR CREMATORIAL ERWIN CEMETERY		23d. LOCATION (City, town or county) DUNN NORTH CAROLINA		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 517 N. 4th SE, Wash. D.C.		ADDRESS		25a. REC'D BY REGISTRAR JUL 28 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Thorne			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8378

CERTIFICATE OF DEATH

33372

Item 7 N.I.D. 110/61 int.

1. PLACE OF DEATH

a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hillcrest Heights

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

e. STATE

Maryland

b. COUNTY

Prince George

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hillcrest Hgts

d. STREET ADDRESS

5312 29th st. Ave

18
b. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Mary

Bessie

Pixton

4. DATE
OF
DEATH

July 3

1961

Month Day Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Female

White

9a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (County & State, or town or country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George H Reidy

14. MOTHER'S MAIDEN NAME

Lucille BUCKLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

NONE Alice CANTERBURY Hillcrest Hgts Md

Address 5312 29th st. Ave

INTERVAL BETWEEN
ONSET AND DEATH

1 hour

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

153.8

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b)

DUE TO

(c)

Acute cardiac insufficiency
Carcinoma of colon with
extensive Metastases.

1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, term,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

10.19 1960 to 7.3 1961

saw the deceased alive on 6.28 1961

and that death occurred at 12:15 P.M. from the causes and on the date stated above.

22e. SIGNATURE

Peter Duius

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS. 22b. DATE
SIGNED
7.3.6122c. PHYSICIAN'S
NAME (Type)

PETER DUIUS

22d. ADDRESS

6124 Central Av

23a. BURIAL, CREMATION
REMOVAL (Specify)

BURIAL 7-6-61

23b. DATE THEREOF

ADDRESS

23c. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

23d. LOCATION (City, town or county)

(State)

FT. LINCOLN CEMETERY, MD.

Capitol Heights Md.

24. FUNERAL DIRECTOR'S SIGNATURE

T. See & Sons

ADDRESS

300 4th St. N.E.

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JUL 5 '61

R. J. S. & Sons



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

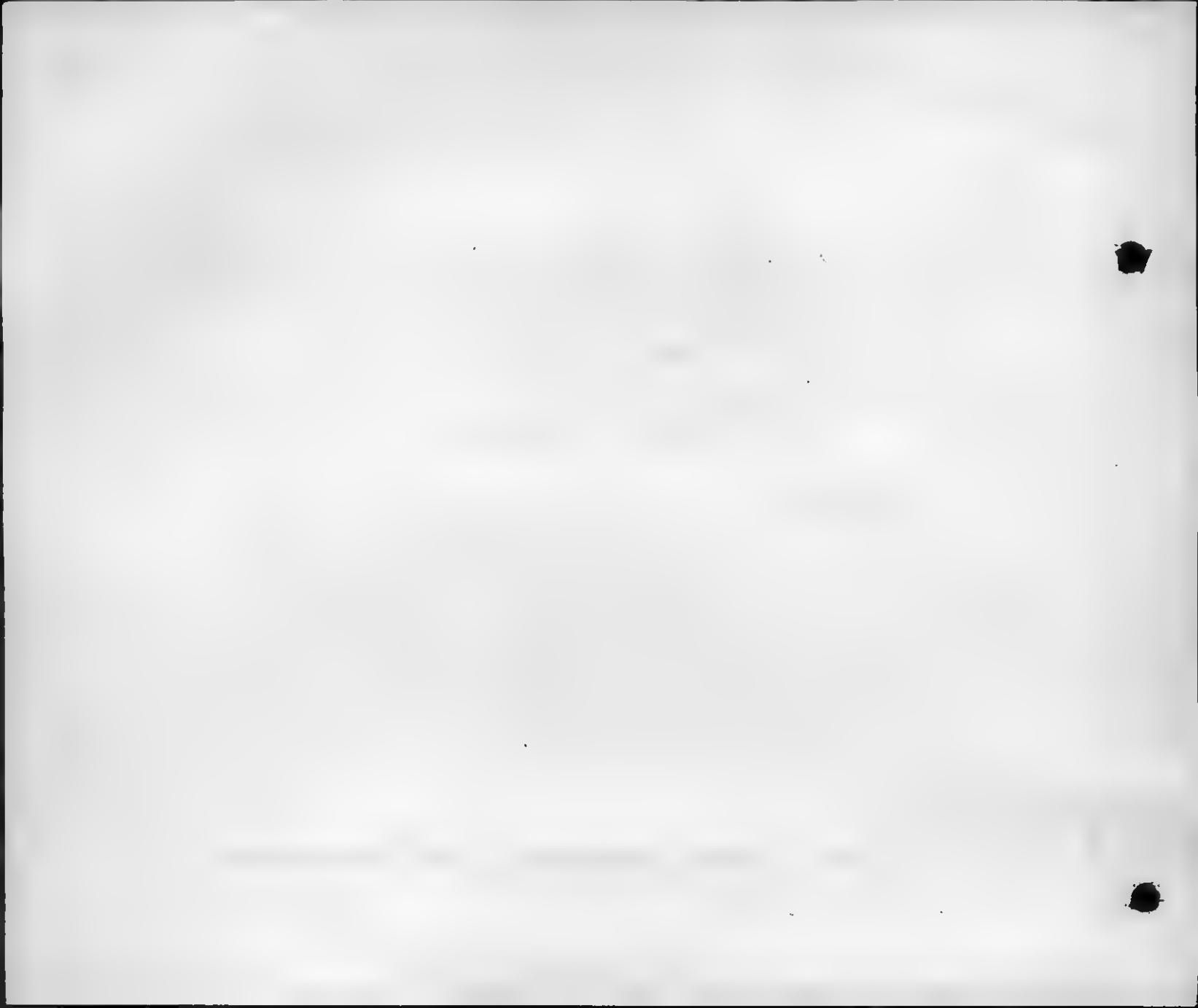
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8379

CERTIFICATE OF DEATH

83373

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Camp Springs</i>		c. LENGTH OF STAY IN lb <i>1 hr. 10 min</i>		a. STATE MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>USAF Hospital Andrews</i>				b. COUNTY <i>Prince George</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>C.</i>	Last <i>Pratt Jr.</i>	4. DATE OF DEATH <i>23 Oct 59</i>	Month Day Year <i>July 21 1961</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>23 Oct 59</i>	9. AGE (in years lost birthday) / yrs <i>1 / 20</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <i>0 20</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) <i>Honolulu Hawaii</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>William C. Pratt</i>	14. MOTHER'S MAIDEN NAME <i>Catherine Briggs</i>		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	16. SOCIAL SECURITY NO <i>None</i>	17. INFORMANT <i>Hospital Chart</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC FAILURE</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>					
754.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>INTRAVENTRICULAR SEPTAL DEFECT</i>					
DUE TO (c) <i>Congenital Heart Disease</i>					
20 months					
20 months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hydrocephalus</i>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <i>July 21 1961</i>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>Arlington, Va</i>	
21. I certify that (this hospital) attended the deceased from <i>21 July 1961</i> to <i>21 July 1961</i> , that (we) last saw the deceased alive on <i>21 July 1961</i> , and that death occurred at <i>1 PM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>Nicholas P. Haritos</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>21 JULY 61</i>	
22c. PHYSICIAN'S NAME (Type) <i>NICHOLAS P HARITOS, Captain USAF MC</i>		22d. ADDRESS <i>USAF HOSPITAL, ANDREWS AFB, MD</i>			
23a. FUNERAL CREMATION REMOVAL (Specify) <i>24 July 1961</i>		23b. DATE THEREOF <i>24 July 1961</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington</i>	
23d. LOCATION (City, town, or county) <i>Arlington, Va</i>				(State)	
24. FUNERAL DIRECTOR'S NAME <i>Funeral Home</i>		ADDRESS <i>816 H St NE</i>		25a. REC'D BY REGISTRAR DATE JUL 24 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	





1
Item 18 Film 306 2/8/63 8 a.m.
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8381

CERTIFICATE OF DEATH

08375

1. PLACE OF DEATH
a. COUNTY

Prince George's MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

72 hours after death

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's Gen. Hospital

3. NAME OF
DECEASED
(Type or print)

Baby Boy

Fst Middle

4. SEX

Male

White

10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

WIDOWED

DIVORCED

13. FATHER'S NAME

Robert Lee Priest

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give rank, dates of service)

Gloria

Ann

Everidge

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Deferred for microscopy

762.0

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Atelectasis of the lungs

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour _____
1:40 p.m. 8 July 1961

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 8, 1961, to July 8, 1961, that (I) (we) last saw the deceased alive on July 8, 1961, and that death occurred at 1:40 P.M. from the causes and on the date stated above.

22e. SIGNATURE

Gordon W. Kelley

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22f. DATE
SIGNED
July 8 1961

22c. PHYSICIAN'S
NAME (Type)

Gordon W. Kelley

22d. ADDRESS

6129-41st Ave. Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

July 11, 1961

23c. NAME OF CEMETERY OR CREMATORIAL

Evergreen Cemetery

23d. LOCATION (City, town or county)

Bladensburg Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

J. Gasch's Sons Hyattsville Md.

ADDRESS

25e. REC'D BY REGISTRAR

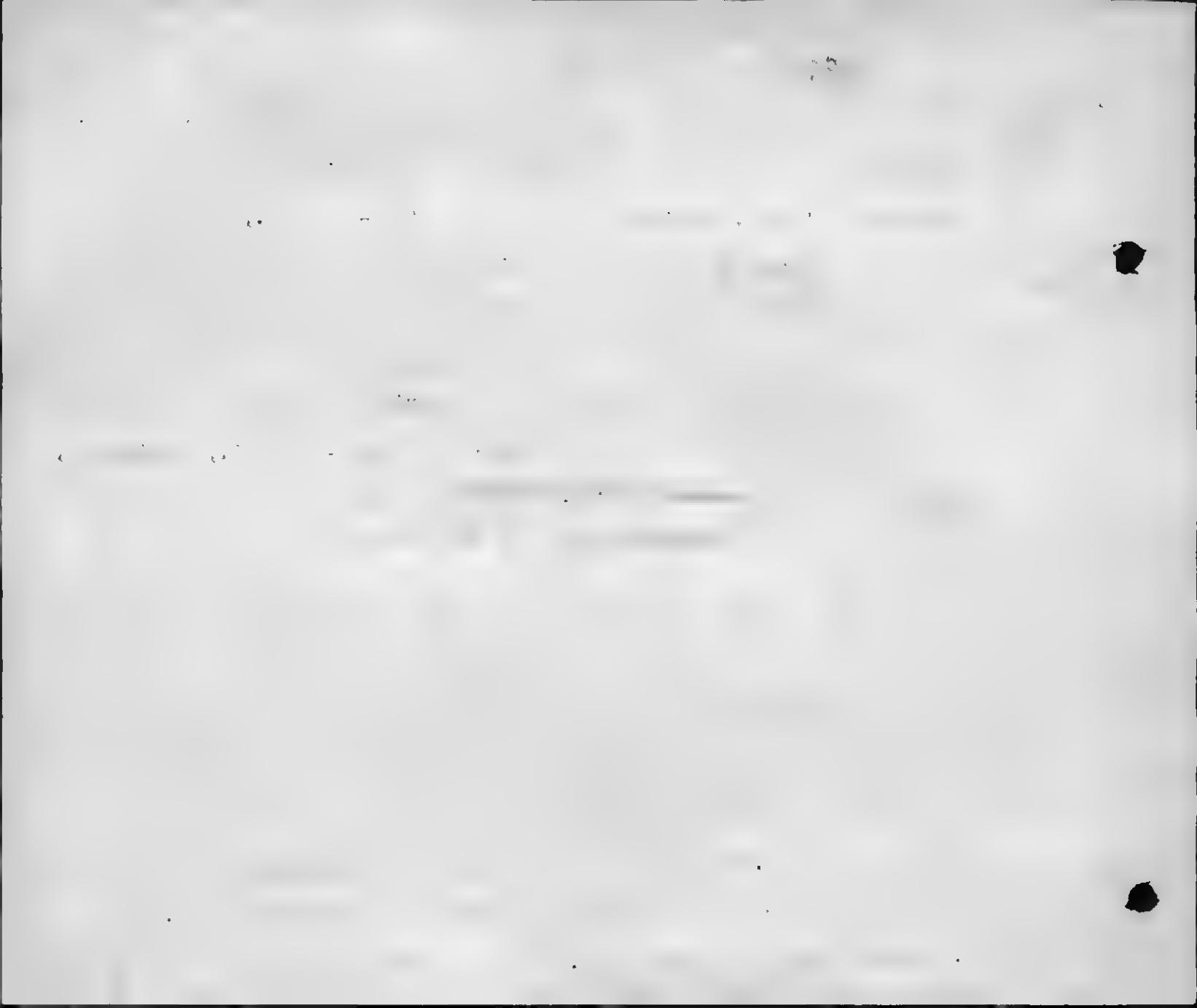
DATE JUL 13 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Times

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 may be retained by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8382

CERTIFICATE OF DEATH

08376

1. PLACE OF DEATH COUNTY Prince Georges		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale		c. LENGTH OF STAY IN 1b 2 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisdale		d. STREET ADDRESS 7309 23rd Ave.				
d. NAME OF HOSPITAL (If not in hospital, give street address) 7309 23rd Ave.				d. STREET ADDRESS 7309 23rd. Ave.		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Eugenie		First	Middle	Last	4. DATE OF DEATH July 18	Month	Day	Year 1961		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 March 1885		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	IF UNDER 24 HRS Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Stanislaus Rolin		14. MOTHER'S MAIDEN NAME Victoria Canuelle								
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Lorraine Q. Cecil Same as # 2 Daughter		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from July 17, 1958 to July 17, 1958 that (I) last saw the deceased alive on July 17, 1961 , and that death occurred at 33 M , from the causes and on the date stated above.										
22a. SIGNATURE <i>Richard L. Whelton</i>		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE 7-18-61							
22c. PHYSICIAN'S NAME (Type) RICHARD L. WHELTON		22d. ADDRESS 1021 University Blvd E. Silver Spring								
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 7/21/61		23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart Cemetery		23d. LOCATION (City, town, or county) Andover		(State) Mass.		
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REG-STAR DATE JUL 2 1961		25b. REGISTRAR'S SIGNATURE <i>in time & true</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, copy the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8383

CERTIFICATE OF DEATH

08377

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 1/2 hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden	
3. NAME OF DECEASED (Type or print) Baby		d. STREET ADDRESS 14th & Lincoln Ave.	
First Baby		Middle Girl	Last Reddick
4. DATE OF DEATH July 1 1961		Month July	Day 1
5. SEX Female		6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1 July 1961		9. AGE (in years last birthday) yrs 1	10. IF UNDER 1 YEAR Months 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aaron Reddick		14. MOTHER'S MAIDEN NAME Rose Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mother		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Atelectasis Prematurity</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1 1961 to July 1 1961 , that (I) (we) last saw the deceased alive on July 1 1961 , and that death occurred at 1030PM from the causes and on the date stated above.		22b. DATE SIGNED	
22c. SIGNATURE <i>John W. Perkins</i>		M.D. <input type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22d. ADDRESS 5301 Hamilton St., Hyattsville, Md.
23a. BURIAL, CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 7-10-61	
23c. NAME OF CEMETERY OR CREMATORIAL Prince George's General Hospital Cheverly, Md.		23d. LOCATION (City, town, or county) (State) Cheverly, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Krause, Jr., Registrar</i>		25a. REC'D BY REGISTRAR DATE JUL 11 '61	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8384

CERTIFICATE OF DEATH

08378

1. PLACE OF DEATH

a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 16

30 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George General Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

e. STATE

Maryland Prince George

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bladensburg

d. STREET ADDRESS

5356 Quincy Place

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF DECEASED
(Type or print)

First MIDDLE

Last DATE OF DEATH

Month July Year 14, 1961

4. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

April 1, 1889

IF UNDER 1 YEAR

Months 72 Days Years 24 hrs.

HOURS

Hours 0 Min.

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Foreman - Retired Suburban Comm Washington Fayette Co. Pa. u.s.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE County & State, or foreign country

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Henry L. Rhodes

14. MOTHER'S MAIDEN NAME

Dora J. Sturgis Address above

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

no no

16. SOCIAL SECURITY NO.

17. INFORMANT

Little A. V. Rhodes

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

332X

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause first.

(b)

DUE TO

(c)

Cerebral Thrombosis

Cerebral Arteriosclerosis

Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner.)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour e.m. While at work p.m. 19

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Sept 1960 to July 14, 1961, that (I) we last saw the deceased alive on July 14, 1961, and that death occurred at home, from the causes and on the date stated above.

22a. SIGNATURE

William D. Rosson MD

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

William D. Rosson

ATTENDING PHYS. M.D.

MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

5701-85 Ave Carrollton Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 7/17/61 Damascus

23d. LOCATION (City, town or county)

(State)

23b. DATE THEREOF

7/17/61

23c. NAME OF CEMETERY OR CREMATORIUM

ADM. Mt. Rainier

25e. REC'D BY REGISTRAR

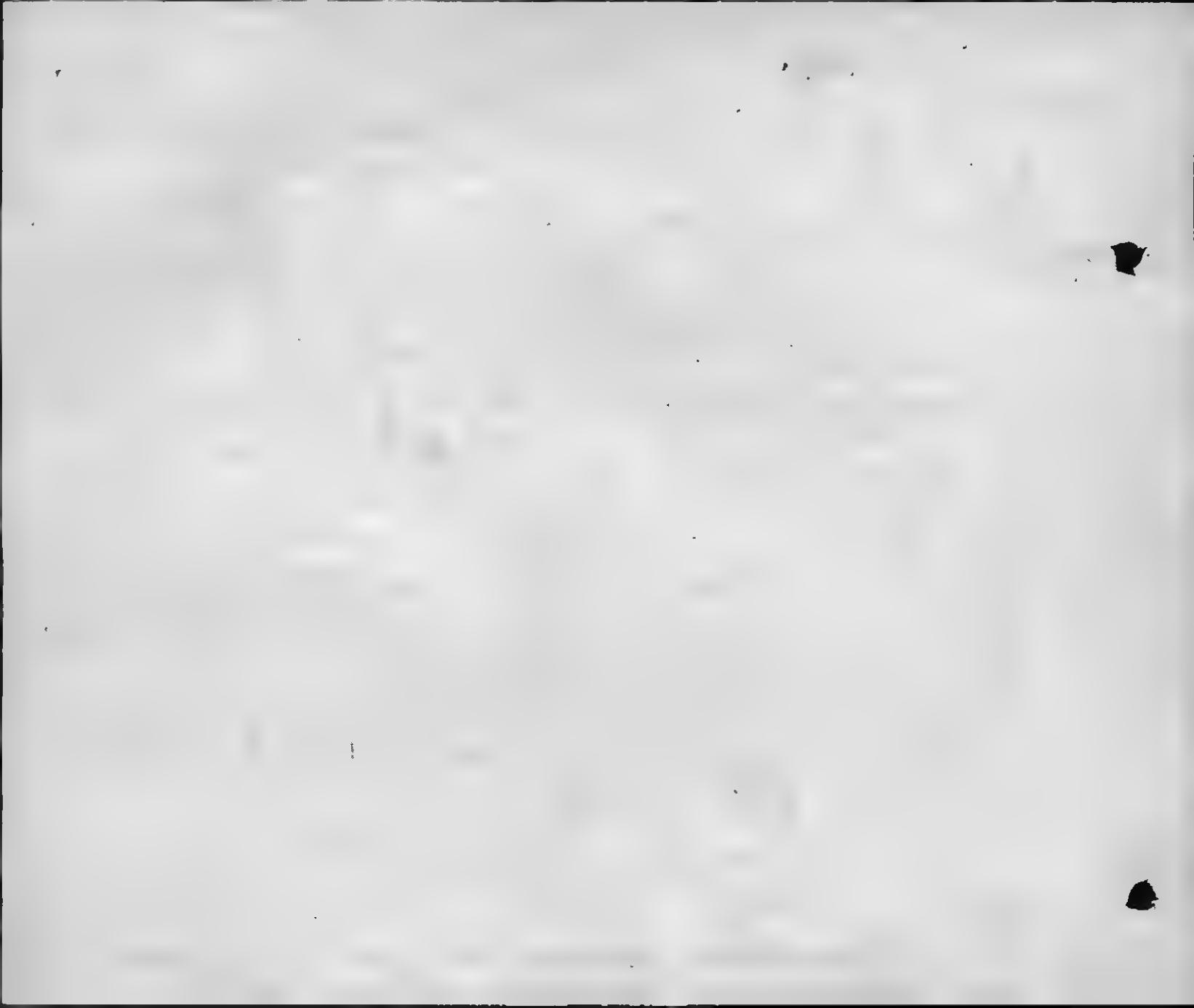
25b. REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR'S SIGNATURE

Nalley's Funeral Home, Prince George, Md.

DATE JUL 18 '61

Signature



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8385

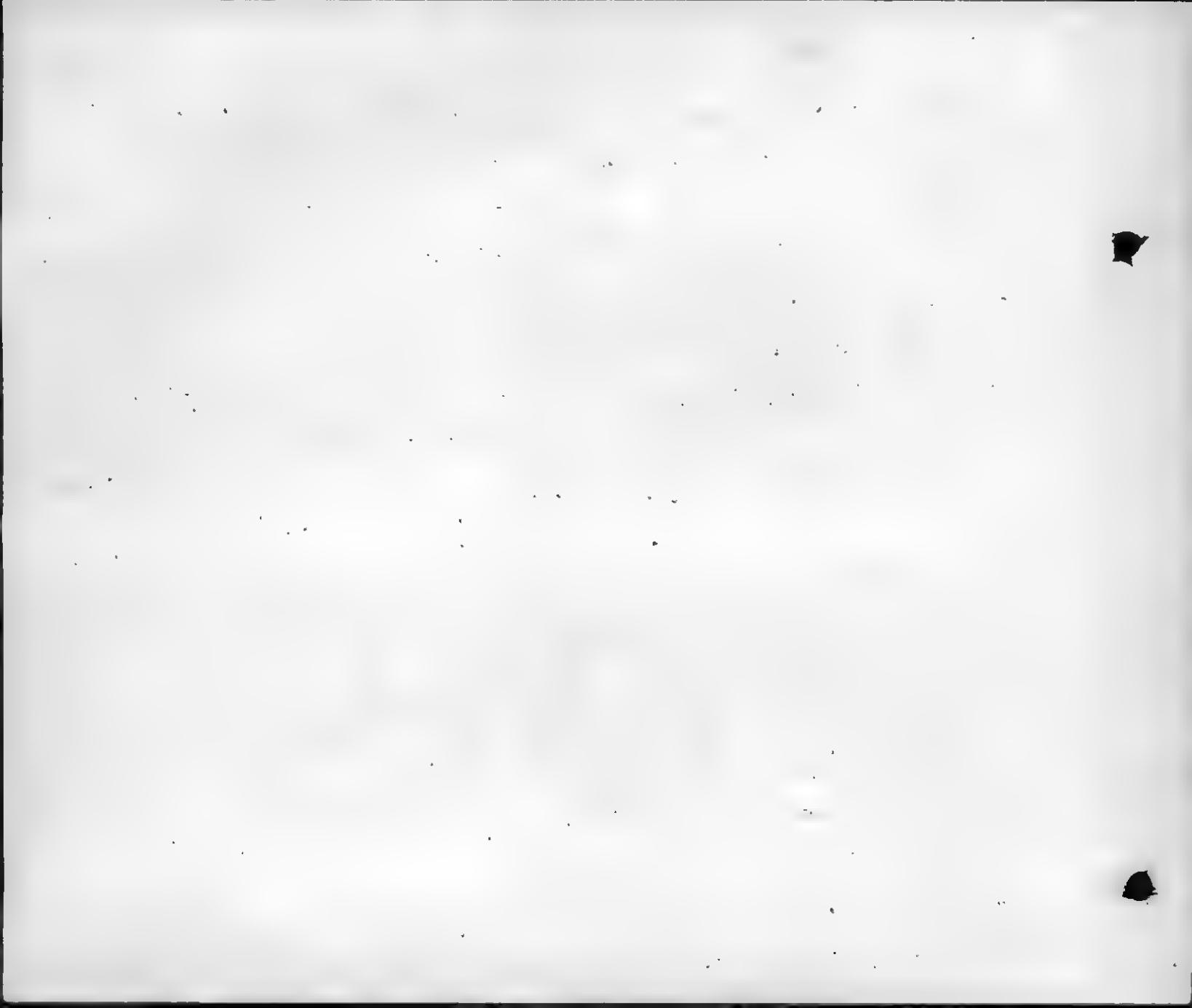
CERTIFICATE OF DEATH

Reg. Dist. No. 83373

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Landover Hills</i>		c. LENGTH OF STAY IN 1b <i>9 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4200-70th Avenue</i>		e. STREET ADDRESS <i>4200-70th Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Anna M. Richtarsic</i>		First <i>Anna</i>	Middle <i>m.</i>
Last <i>Richtarsic</i>		4. DATE OF DEATH <i>8 July 14th 1961</i>	Month Day Year
5. SEX <i>Female</i>		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>9/7/1895</i>		9. AGE (In years at birth) <i>65</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Practical nurse Nursing</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Crenshaw, Pa.</i>	
11. BIRTHPLACE (State or foreign country) <i>Crenshaw, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Louis M. Richtarsic</i>		14. MOTHER'S MAIDEN NAME <i>Victoria Chernisky</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. <i>263-16-1612</i>	
17. INFORMANT <i>mrs. Robert Murphy</i>		Address <i>4200-70th Ave Landover Hills, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition & Cachexia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Generalized abdominal metastases</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DUE TO <i>17/18</i>		<i>1 yrs.</i>	
(b) DUE TO <i>Carcinoma of the Cervix</i>		<i>3 yrs.</i>	
(c)			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1 May 1961</i> to <i>14 Jul 1961</i> , that I last saw the deceased alive on <i>14 Jul 1961</i> , and that death occurred at <i>10:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Thomas J. Maloney</i>		ADDRESS (Street, city or town, state) <i>4814-71st Ave.</i>	
PHYSICIAN'S NAME (Type) <i>THOMAS J. MALONEY</i>		DATE SIGNED <i>14 Jul 61</i>	
22a. BURIAL, CREMAT. ON REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/18/61</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>St. John's Cemetery</i>		22d. LOCATION (City, town, or county) <i>Brockway Jefferson Co., Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kelley's Funeral Home</i>		24a. REC'D BY REGISTRAR <i>John L. Rainier</i>	
ADDRESS <i>110 E. Rainier</i>		24b. REGISTRAR'S SIGNATURE <i>John L. Rainier</i>	
DATE <i>7/18/61</i>		DATE <i>7/18/61</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8385

CERTIFICATE OF DEATH

08380

1. PLACE OF DEATH
a. COUNTY

Prince George

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

3 Days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Lucie

M

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

B DATE OF BIRTH

WIDOWED DIVORCED

Apr. 23, 1886

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired-Auditor

10b. KIND OF BUSINESS OR INDUSTRY

U.S. Govt.

11. BIRTHPLACE (County & State, or foreign country)

Virginia

13. FATHER'S NAME

Joseph Armentrout

14. MOTHER'S MAIDEN NAME

Cornelia Bare

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT
(Yes, no, or unknown) (If yes give rank or dates of service)

Roy R. Robertson

5321—Que St., S.E.
Wash. 27, DC

Address

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (e)Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

Hypertension
Parkinson DiseaseINTERVAL BETWEEN
ONSET AND DEATH
1 weekPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not While
Hour a.m. at work at work
p.m. 19
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1961 to July 8, 1961, that (I) (we) last saw the deceased alive on 1961, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Bogus Pecson

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED
22d. ADDRESS7028 Marlboro Pike,
District Heights, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION (City, town or county) (State)

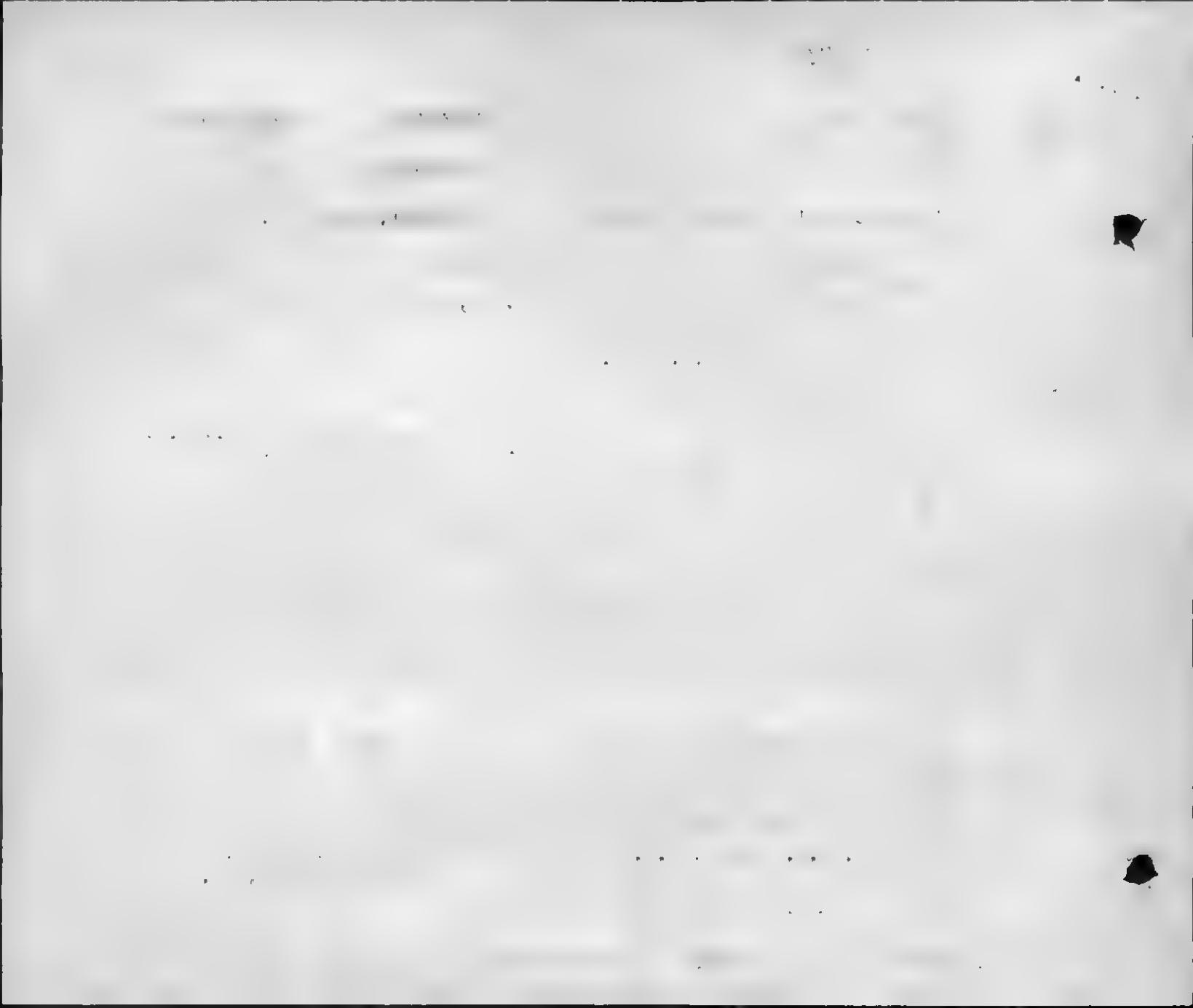
Burial

7-7-61

Evergreen Cemetery

Roanoke, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
SIMMONS BROTHERS 1661-Good Hope Rd. S.E. DATE JUL 10 '61
Caring & Keene



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8387

CERTIFICATE OF DEATH

02381

1.		2.		3.		4.		5.	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician and copies filed in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be detached from use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.		PLACE OF DEATH		USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		NAME OF CEMETERY OR CREMATORIAL	
M		8		FRINK GEORGES		a. STATE		LA PLATA, MD.	
I		3.		COUNTY		b. COUNTY		(Specify)	
		4.		CLINTON		CHARLES		REMOVAL	
		5.		MARYLAND		ADDRESS		LOCATION (City, town or county) (State)	
		6.		MARYLAND		23a. BURIAL, CREMATION, DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL	
		7.		LENGTH OF STAY IN 1b		23b. DATE THEREOF		23d. LOCATION (City, town or county) (State)	
		8.		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		ADDRESS		LA PLATA, MD.	
		9.		NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		24. FUNERAL DIRECTOR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE	
		10.		SOUTHERN MARYLAND HOSP. CENTER		The Hunt Funeral Home, Waldorf, MD.		Arthur S. Kraus	
		11.		NAME OF DECEASED (Type or print)		First		DATE OF DEATH	
		12.		EDITH		Middle		Month	
		13.		F		Last		Day	
		14.		WHITE		ROBEY		Year	
		15.		COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		JULY	
		16.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
		17.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		3 - 11 - 89		IF UNDER 1 YEAR	
		18.		10b. KIND OF BUSINESS OR INDUSTRY		72 yrs.		IF UNDER 24 HRS.	
		19.		11. BIRTHPLACE (County & State, or foreign country)		MARYLAND		Months	
		20.		12. CITIZEN OF WHAT COUNTRY?		U.S.A.		Days	
		21.		13. FATHER'S NAME		George E. Lyon		Hours	
		22.		14. MOTHER'S MAIDEN NAME		Francis E. Robey		Min.	
		23.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)		NO		Address	
		24.		16. SOCIAL SECURITY NO.		PAVI ROBEY, WALDORF, MD.		INTERVAL BETWEEN ONSET AND DEATH	
		25.		17. INFORMANT		Acute Pyelonephritis		3-4 days	
		26.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		CVA (Cerebral Thrombosis)		16 days	
		27.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Generalized Arterial Sclerosis		years	
		28.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } DUE TO (b)		General Disability			
		29.		} DUE TO (c)					
		30.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				19. WAS AUTOPSY PERFORMED?	
		31.		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		32.		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		33.		20f. (City or town) (County) (State)					
		34.		21. I certify that (I) (this hospital) attended the deceased from 6/22/61 to 7/9/61, 1961, that (I) (we) last saw the deceased alive on 7/9/61, 1961, and that death occurred at 11:30 A.M. from the causes and on the date stated above.					
		35.		22e. SIGNATURE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
		36.		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
		37.		23a. BURIAL, CREMATION, DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)	
		38.		REMOVAL (Specify)		Mt Rest		LA PLATA, MD.	
		39.		24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR	
		40.		The Hunt Funeral Home, Waldorf, MD.				DATE JUL 12 '61	
		41.		25b. REGISTRAR'S SIGNATURE					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8388

CERTIFICATE OF DEATH

08382

1. PLACE OF DEATH

a. COUNTY

Prince George

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George General Hospital

3. NAME OF

DECEASED
(Type or print)

MADELYN M.

c. LENGTH OF STAY IN HB

8 Days

First Middle

5. SEX

Female

b. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Roche

Nov. 21, 1899

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

521.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

1 Respiratory Failure.
Portal Circrosis.INTERVAL BETWEEN
ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED
p.m. While at work Not While at work
19 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)21. I certify that (I) (this hospital) attended the deceased from Jesus, 1961 to July 22, 1961, that (I) (we) last saw the deceased alive on 7/22/61, and that death occurred at 7:30 A.M. from the causes and on the date stated above.22a. SIGNATURE Dr. Leon Levitsky22b. DATE SIGNED 7/22/61

22c. PHYSICIAN'S NAME (Type) Dr. Leon Levitsky, M.D.

M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22d. ADDRESS

3408 Rhode Island Ave. Int. Bldg., 2nd New Haven, Conn.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Burial July 25 '61 St. Bernard's Art. Rainier

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Nalley's Funeral Home, Inc.25a. REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE JUL 24 '61 Arthur S. Head

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15 P/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8389

CERTIFICATE OF DEATH

03383

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood Md.	c. LENGTH OF STAY IN lb 56 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3800 Taylor Street		d. STREET ADDRESS 3800 Taylor Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) James Edward		First Sampson Middle Last 	4. DATE OF DEATH July 14, 1961
S SEX male	5 COLOR OR RACE white	6 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7 DATE OF BIRTH Dec 19, 1873
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		9. KIND OF BUSINESS OR INDUSTRY Navy Yard	10. BIRTHPLACE (State or foreign country) Virginia
11. CITIZEN OF WHAT COUNTRY? U S A		12. FATHER'S NAME William Sampson	
13. MOTHER'S MAIDEN NAME Georgeanna Drake		14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
15. SOCIAL SECURITY NO. none		16. INFORMANT Lucy Sampson	Address Brentwood, Md.
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema INTERVAL BETWEEN ONSET AND DEATH 2-4 hrs			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease 17 years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Sensitivity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9 - 19 - 1944 to 7 - 14 - 1961 , that (I) (we) last saw the deceased alive on 7 - 14 - 1961 , and that death occurred at 11 AM , from the causes and on the date stated above			
22a. SIGNATURE Waldo B. Moyers		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Waldo B. Moyers		22d. ADDRESS 3503 Perry St. Mt. Rainier Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/18/61	23c. NAME OF CEMETERY OR CREMATORIAL Ft Lincoln Cemetery	23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE JUL 19 '61
			25b. REGISTRAR'S SIGNATURE Charles S. Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours have not passed, the physician or attending physician must sign the certificate.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8390

CERTIFICATE OF DEATH

08384

1. PLACE OF DEATH
a. COUNTY

Prince Georges **X** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly 2 hr

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle Last

Baby

Boy

Savoy

5. SEX

6. COLOR OR RACE

Male

Black

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

11 July 1961

4. DATE
OF
DEATH

11 July 1961

Month

Day

Year

9. AGE (in years
(last birthday))

Months Days Hours Mins.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

yrs.

2

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

William Lorraine Savoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give war or date of service)

Mayyland

14. MOTHER'S MAIDEN NAME

Mary Alice Chapman

Address

U.P.A.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Premature

776X
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN
ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,
Hour a.m. While at work Not While at work factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

p.m.

19

21. I certify that (I) (this hospital) attended the deceased from 11 July 1961 to 11 July 1961 that (I) (we) last saw the deceased alive on 11 July 1961, and that death occurred at 6:30A from the causes and on the date stated above.

22a. SIGNATURE
T. A. Christensen

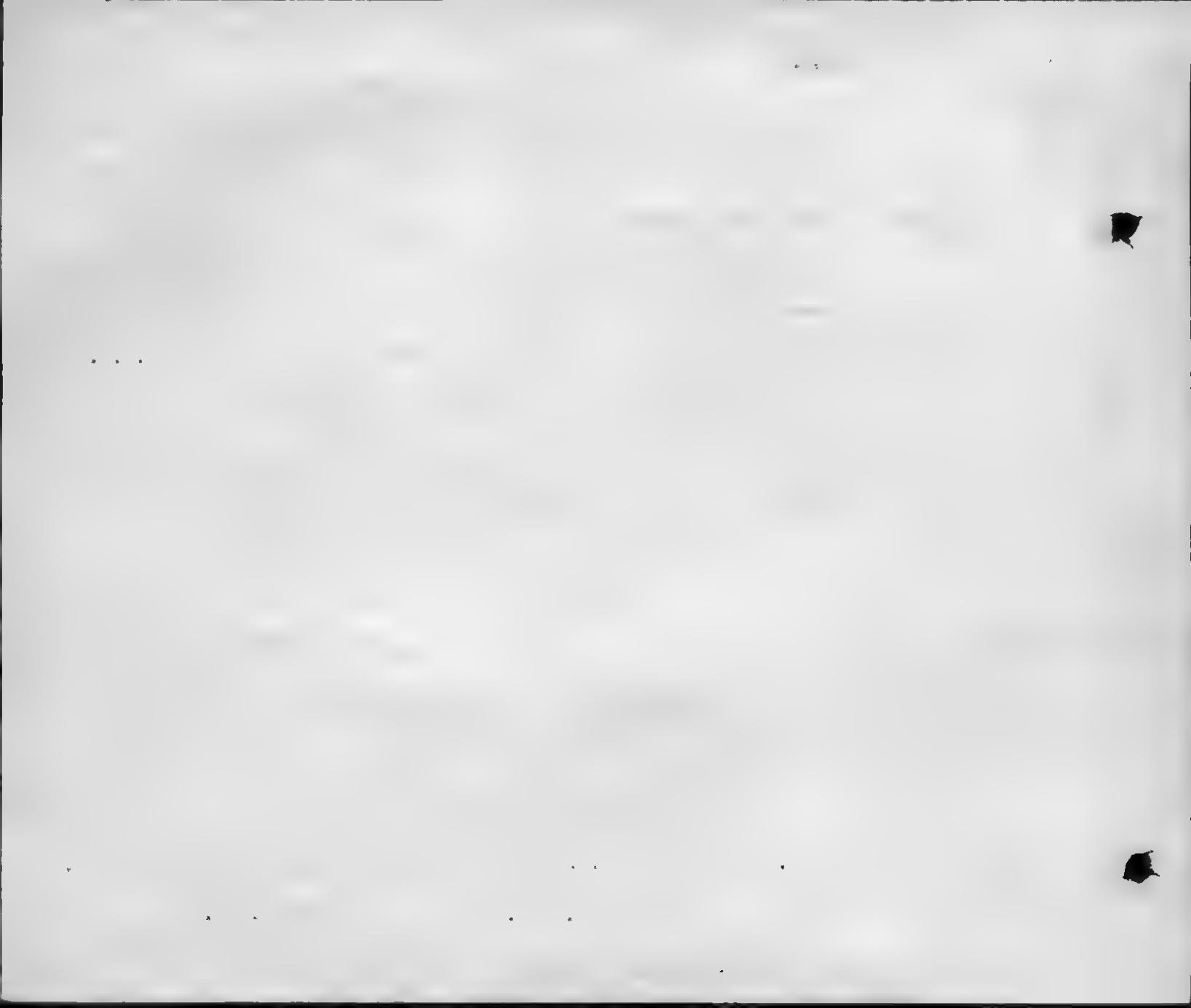
ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)
Thomas A. Christensen, M.D. 22d. ADDRESS
6905 Baltimore Ave., College Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation 23b. DATE THEREOF
7/22/61 23c. NAME OF CEMETERY OR CREMATORIAL
Prince Geo. Gen. Hospital 23d. LOCATION (City, town or county)
Cheverly, Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE
Harry W. Penn Jr. ADDRESS
DATE JUL 24 '61 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
CURTIS S. KLINE



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

M

8391

8385

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY

Prince George

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hyattsville

c. LENGTH OF STAY IN 1b

8 Years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospice, give street address)

Sacred Heart Home

3. NAME OF
~~DECEASED~~
(Type or print)

First

Middle

Annie

T. Schubert

4. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

WIDOWED DIVORCED

July 4th 1876

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Invalid

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Washington, D. C.

13. FATHER'S NAME

Martin Schubert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give rank or dates of service)

9. AGE (In years last birthday)

85 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Barbara Bernstein

Address

Sacred Heart Home Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.
(b) DUE TO
(c)

Coronary Thrombosis with Myocardial Infarction

Arteriosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. City or town)
p.m. While at work Not White factory, street, office bldg., etc.) (County) (State)
19 at work at work

21. I certify that (I) (XXXXXX) attended the deceased from 6/30/1961 19 to 7/14/1961 19, that (I) (XX) last saw the deceased alive on 7/13/1961 19, and that death occurred at 8:49 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Thomas F. Collins

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.
M.D.
22d. ADDRESS 322-H St. N.E. Wash. 2, D.C.

7/14/1961 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

Thomas F. Collins, M.D.

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

Burial July 17-1961

23c. NAME OF CEMETERY OR CREMATORIUM

St. Mary's Cemetery

23d. LOCATION (City, town or County)

Washington, D.C. (State)

24. FUNERAL DIRECTOR'S SIGNATURE

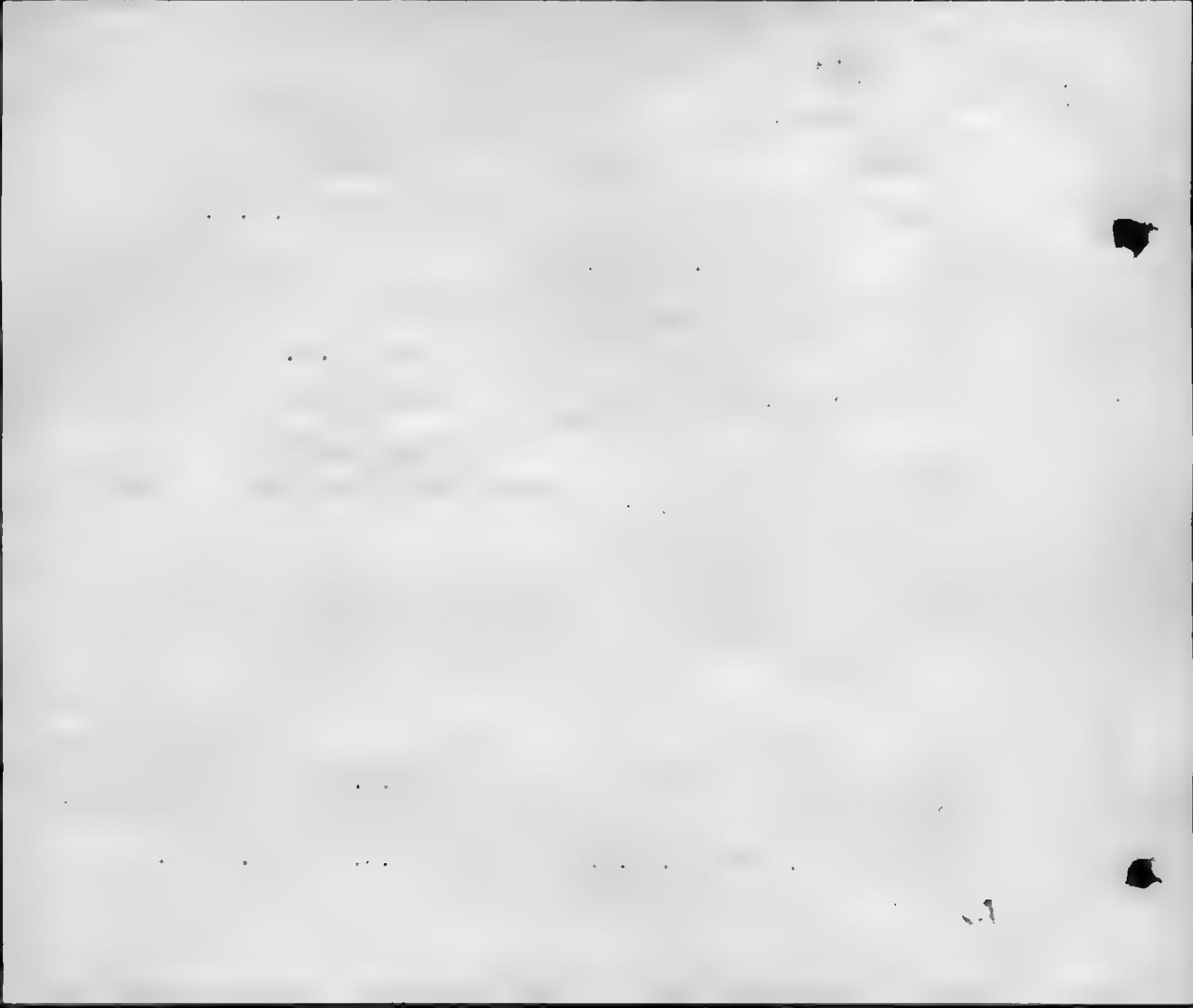
ADDRESS J. F. Costello, 1722 N. Capital St. D.C. DATE JUL 17 '61

25a. REC'D BY REGISTRAR

Charles S. Kraus

INTERVAL BETWEEN
INSET AND DEATH
24 hours

4 years



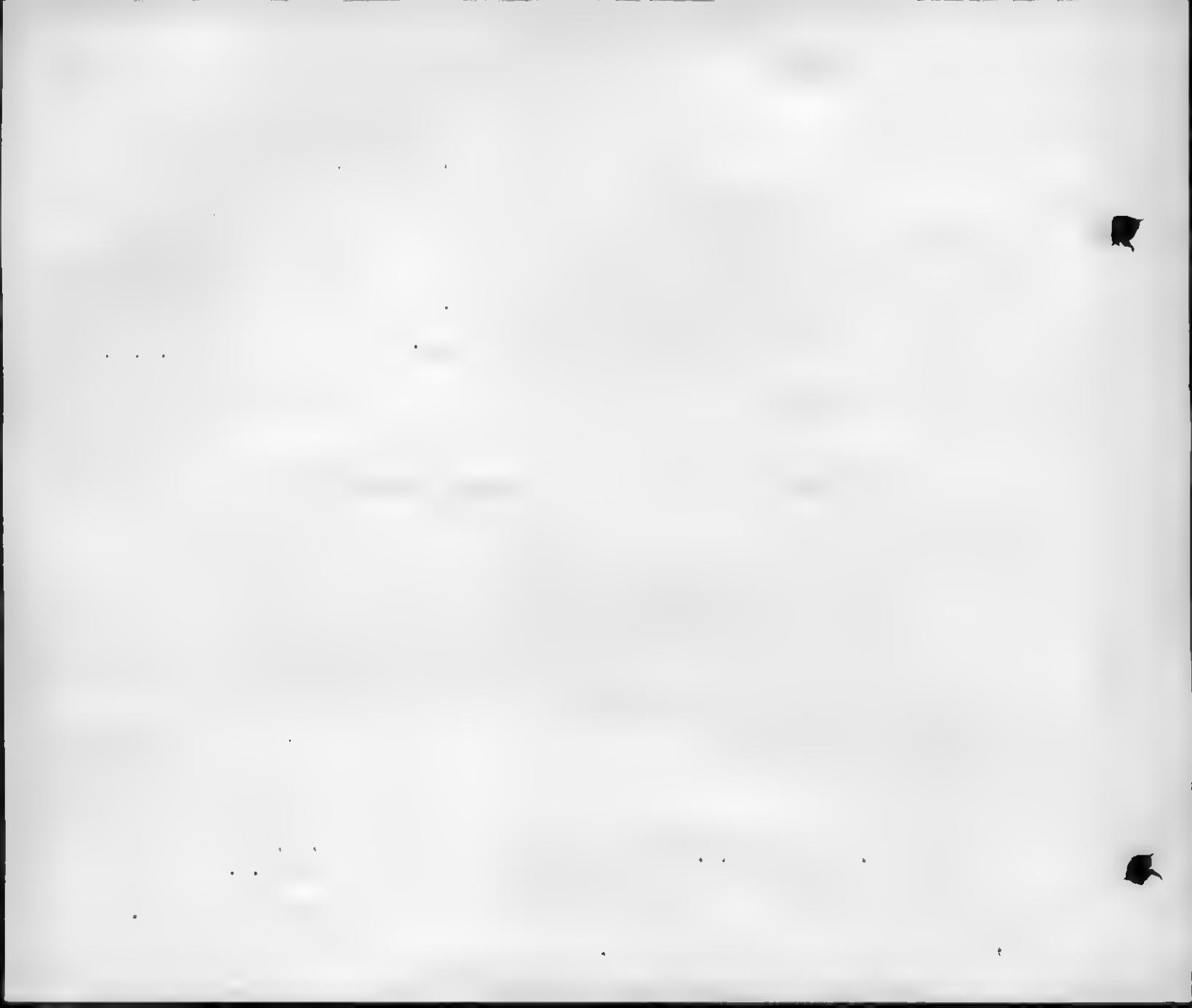
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8392

08386

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale			
NAME OF DECEASED (Type or print) Lilly		First L	Middle W	Last Seay	4 DATE OF DEATH July	Month July	Day 13	Year 1961	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S. SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3 Sept. 1869	9. AGE (In years last birthday) 91	10. IF UNDER 1 YEAR Months 91	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles Harbaugh				14. MOTHER'S MAIDEN NAME Mary J. Warren					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Hospital Record		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sarcoma left shoulder with metastases						INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
199X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO							
		DUE TO							
		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 12, 1961 , to July 13, 1961 , that (I) (we) last saw the deceased alive on July 13, 1961 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.									
22a. SIGNATURE James R. Goodson		M.D. ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED July 14/61	
22c. PHYSICIAN'S NAME (Type) James R. Goodson, M.D.		22d. ADDRESS 1746 K St. N.W. Washington 6, D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/16/61		23c. NAME OF CEMETERY OR CREMATORIAL Confederate Cemetery		23d. LOCATION (City, town, or county) Spotsylvania		(State) Va.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gacash's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 17 '61		25b. REGISTRAR'S SIGNATURE Carlton S. Krebs			



FOR STATE
HEALTH DEPT.



delay is necessary,
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8393 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0838

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Leon

5. SEX

Male

6. COLOR OR RACE

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Electrician

13. FATHER'S NAME

Isadore Sherman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank or date of service)

Yes

16. SOCIAL SECURITY NO.

1932-34 578-01-4131

17. INFORMANT

Gary Sherman,

same as #2

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Myocardial Infarct

Coronary Thrombosis and Arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

July 31, 1961

ACTUAL
SIGNATURE

James I. Boyd

EXAMINER'S
NAME (Type)

JAMES I. BOYD, M.D.

22e. BURIAL, CREMATION
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR Crematory

22d. LOCATION (City, town, or country)

(State)

Burial

8-2-61

B'Nai Israel Cemetery

Oxon Hill, Maryland

23. FUNERAL DIRECTOR

ADDRESS

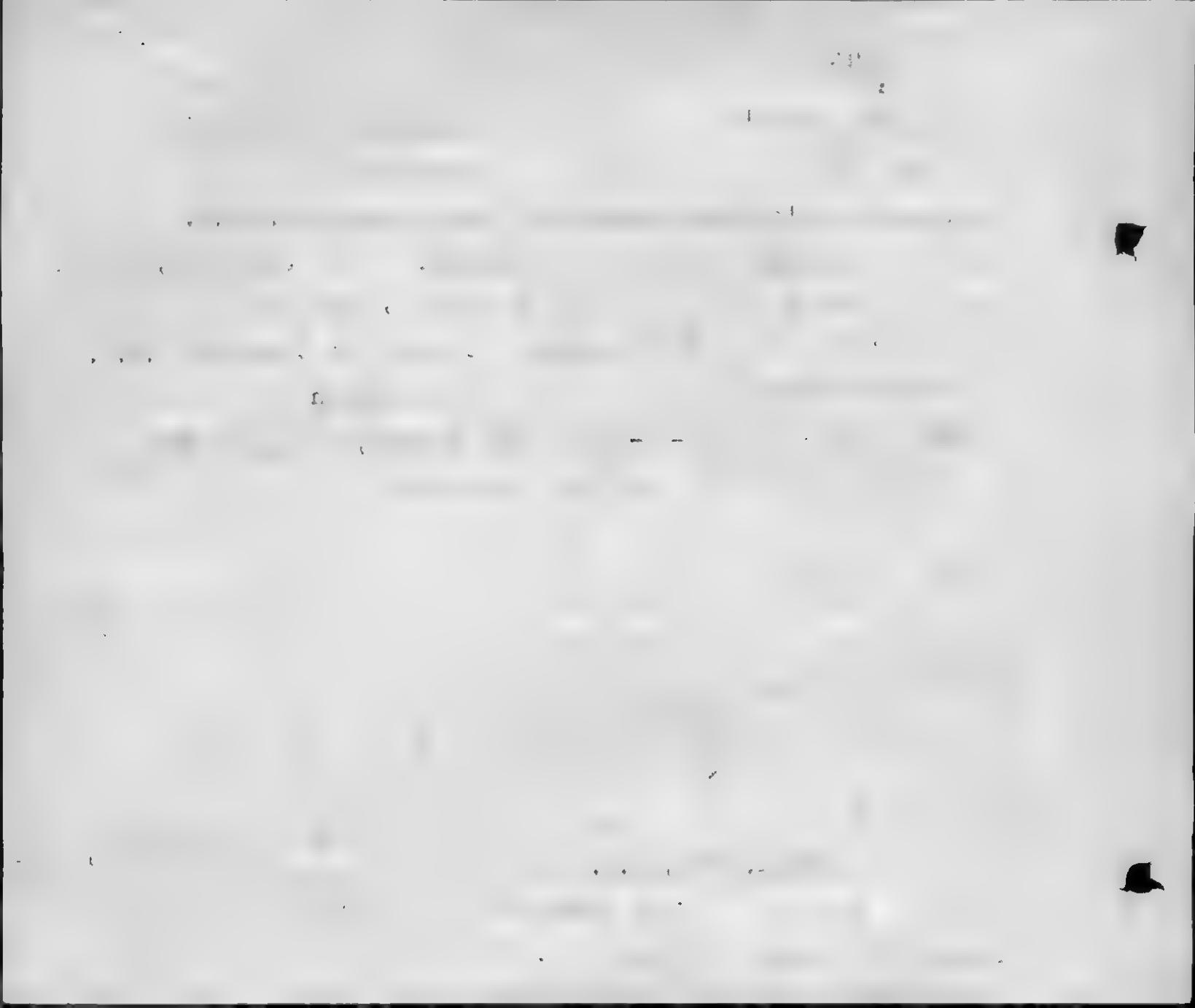
24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE

AUG 4 '61

Charles L. Kraus



M

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8394

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00383

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 13 Hr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lillian	Middle Mae	Last Shirley
4. DATE OF DEATH	Month July	Day 28	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 16, 1890
9. AGE (In years last birthday) 71 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	11. KIND OF BUSINESS OR INDUSTRY AT HOME	12. BIRTHPLACE (State or foreign country) GEORGIA
13. CITIZEN OF WHAT COUNTRY? USA	14. FATHER'S NAME CHARLES R. HERRING	15. MOTHER'S MAIDEN NAME LIZA JANE MARTIN	16. SOCIAL SECURITY NO.
17. INFORMANT	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis <small>132 X DUE TO</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</small> <small>(b) DUE TO</small> <small>(c)</small>			
INTERVAL BETWEEN ONSET AND DEATH 36 hrs			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIO SCLEROTIC HYPERTONIC DISEASE			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 7/20 1961			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 7/20 1961 to 7/22 1961 , that (I) (we) last saw the deceased alive on 7/22 1961 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Norman Comeau		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7/22/61
22c. PHYSICIAN'S NAME (Type) Dr. Norman Comeau, M.D.			
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/25/61	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS FORT LINCOLN CEMETERY 3503 CLEVELAND AVE	23d. LOCATION (City, town, or county) BLADENSBURG MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE Frederick W. Chamberlain	25a. REC'D BY REGISTRAR DATE JUL 25 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Evans	



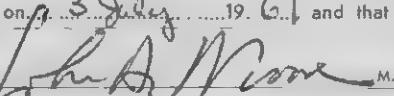
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Age 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

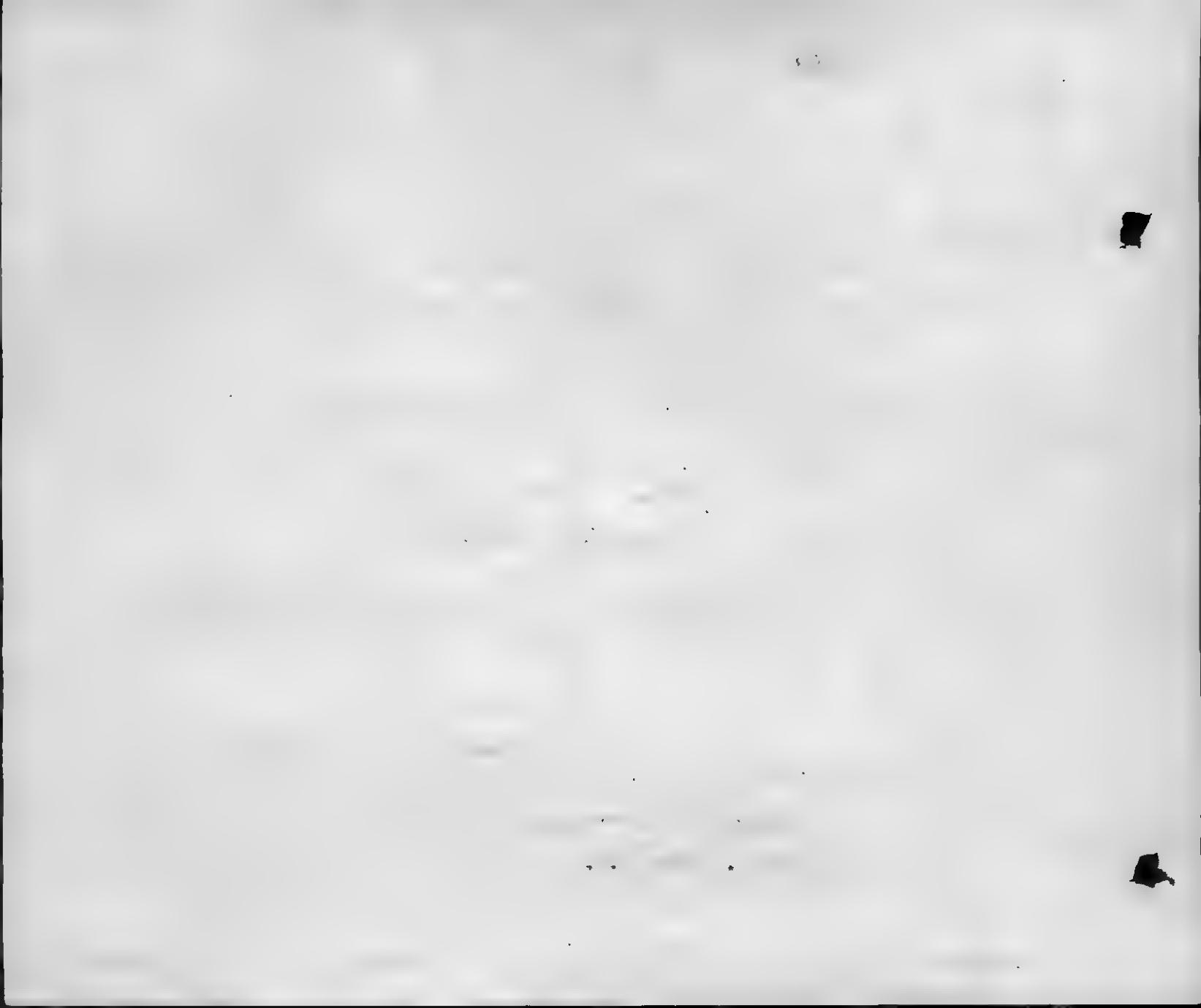
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8395

38383

M		PLACE OF DEATH a. COUNTY Princess Georges	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	b. COUNTY Princess Georges					
		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D.C.	c. LENGTH OF STAY IN 1b 21	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	d. STREET ADDRESS 2503 Riviera St. S.E.					
I		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF Hospital Andrews	First SUSAN	Middle Lynn	4. DATE OF DEATH Month July Day 4 Year 1961					
		3. NAME OF DECEASED (Type or print) SUSAN LYNN Simpson	5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 June 1958	9. AGE (in years last birthday) 3 yrs. IF UNDER 1 YEAR Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (County & State, or foreign country) SAN Antonio, TEXAS	12. CITIZEN OF WHAT COUNTRY? USA
		13. FATHER'S NAME Robert A. Simpson	14. MOTHER'S MAIDEN NAME Margaret A. Godlove	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give rank or dates of service No	16. SOCIAL SECURITY NO	17. INFORMANT Father	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Congenital Heart Disease (c)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION		PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)								20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
		20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> a. work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
		21. I certify that (I) (this hospital) attended the deceased from ... 16 August, 1960 to ... 3 July, 1961, that (I) (we) last saw the deceased alive on ... 3 July, 1961, and that death occurred at 9:55 AM, from the causes and on the date stated above.								
		22a. SIGNATURE 	22b. DATE SIGNED 4 Jul 61							
		22c. PHYSICIAN'S NAME (Type) John A. Moore M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>					
		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1 July 1961	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	23d. LOCATION (City, town or county) Arlington, Va. (State)					
		24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home Inc.	ADDRESS 816 H St. N.E.	25a. REC'D BY REGISTRAR DATE JUL 6 '61	25b. REGISTRAR'S SIGNATURE Charles E. Thomas					



FOR STATE
HEALTH DEPT.

M

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TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If delay is necessary, please indicate the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8395

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8395

1. PLACE OF DEATH
a. COUNTY

Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

College Park

d. NAME OF HOSPITAL OR INSTUTION (if not in hospital, give street address)

8811 Rhode Island Avenue

3. NAME OF
DECEASED
(Type or print)

First

MARYLAND

c. LENGTH OF STAY IN lb

Middle
G.

5. SEX

6. COLOR OR RACE

Female

White

7. MARRIED NEVER MARRIED

b. DATE OF BIRTH

W DOWED

DIVORCED

July 22, 1888

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Own Home

Virginia

13. FATHER'S NAME

John Stanley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

14. MOTHER'S MAIDEN NAME

Anna Rhinner

Address

Marion Simms, same as # 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

442 X

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

Acute congestive heart failure

Cardiovascular renal disease -

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT. ON G. VEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

July 14th., 1961

Address (Street, city, town, or county)

22d. LOCATION (City, town, or country)

(State)

Hyattsville, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

22c. NAME OF CEMETERY OR Crematory

23. FUNERAL DIRECTOR

ADDRESS

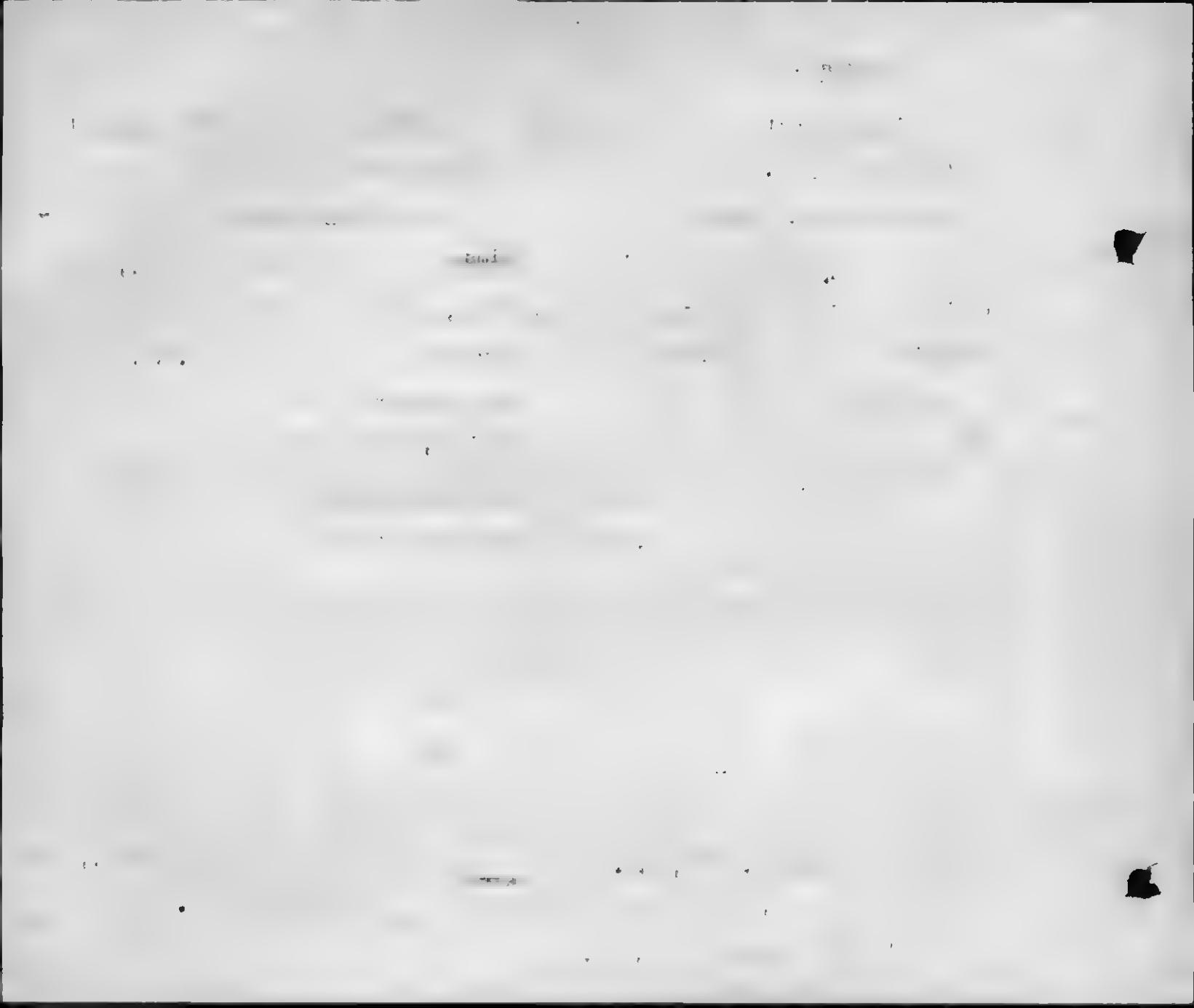
F; Gasch's Sons, Hyattsville, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE JUL 18 '61

Julian L. Turner



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8397

08391

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Prince George</i> MARYLAND		<i>Maryland</i> Piney Bay	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Kirkland Maryland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Aless Manor</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <i>103 Audrey Lane 205</i>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year <i>July 7 1961</i>	
First <i>Joseph</i> Middle <i>Franak</i>		Lost	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-21-1912</i>	
9. WIDOWED <input type="checkbox"/>		10. KIND OF BUSINESS OR INDUSTRY <i>Mechanics</i>	
11. BIRTHPLACE (State or foreign country) <i>Windham Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Joseph F. Sliva</i>		14. MOTHER'S MAIDEN NAME <i>Maria Miallo</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Susan M. Sliva</i>		18. ADDRESS <i>Same as above</i>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Carcinoma, lung with mediastinal</i> DUE TO <i>metastases</i> INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) _____ DUE TO } (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> 20d. INJURY OCCURRED p. m. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i>Washington D.C.</i> (County) <i>District of Columbia</i> (State) <i>D.C.</i>		21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 3 1960</i> to <i>July 7 1961</i> , that (I) (we) last saw the deceased alive on <i>July 7 1961</i> , and that death occurred at <i>6:54 AM</i> , from the causes and on the date stated above.	
22a. SIGNATURE <i>Frank R. Shea</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>FRANK R. SHEA</i>		22d. ADDRESS <i>4100 - 22nd & E Wash DC</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-10-1961</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven</i>		23d. LOCATION (City, town, or county) <i>Silver Spring, Md</i> (State) <i>Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert J. Hyattingly</i>		25a. REC'D BY REGISTRAR <i>Cuthbert S. Kline</i> DATE <i>JUL 10 '61</i>	
ADDRESS <i>131-11 1/2 St & E</i>		25b. REG STRR'S SIGNATURE <i>Cuthbert S. Kline</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
8398				CERTIFICATE OF DEATH							
1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr. George</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel, Laurel</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i>				LENGTH OF STAY IN lb <i>Rural and give nearest town</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>				d. STREET ADDRESS <i></i>							
3. NAME OF DECEASED (Type or print) <i>Joseph Daniel Smith</i>				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 13 1875</i>		9. AGE (In years less birthday) <i>86 yrs</i>		10. UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <i>Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>				11. BIRTHPLACE (State or foreign country) <i>Pr. George Maryland USA</i>			
13. FATHER'S NAME <i>John Smith</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Walker</i>				12. CITIZEN OF WHAT COUNTRY? <i></i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i>				16. SOCIAL SECURITY NO. <i></i>				17. INFORMANT <i>Rutherford Smith, Laurel, Md.</i> Address <i></i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO <i>1 day</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Cerebral Arteriosclerosis 10 yrs</i> (c) DUE TO <i>Ben'l Arteriosclerosis 20 yrs</i>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Laurel</i> (County) <i>Laurel</i>		(State) <i>Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>5/28/61</i> to <i>7/1/61</i> , 1961, that (I) (we) last saw the deceased alive on <i>6/30/61</i> , and that death occurred at <i>3 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>J. M. Warren</i>				M. D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>7/1/61</i>			
22c. PHYSICIAN'S NAME (Type) <i>J. M. Warren</i>				22d. ADDRESS <i>Laurel, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>July 3, 1961</i>		23c. NAME OF CEMETERY OR Crematory <i>St. Paul Cemetery</i>		23d. LOCATION (City, town, or county) <i>Laurel</i> (State) <i>Md.</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Walker</i>				ADDRESS <i>Arthur S. Walker</i>				25a. REC'D BY REGISTRAR <i>DATUL 5 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Walker</i>	



1
FOR STATE
HEALTH DEPT.

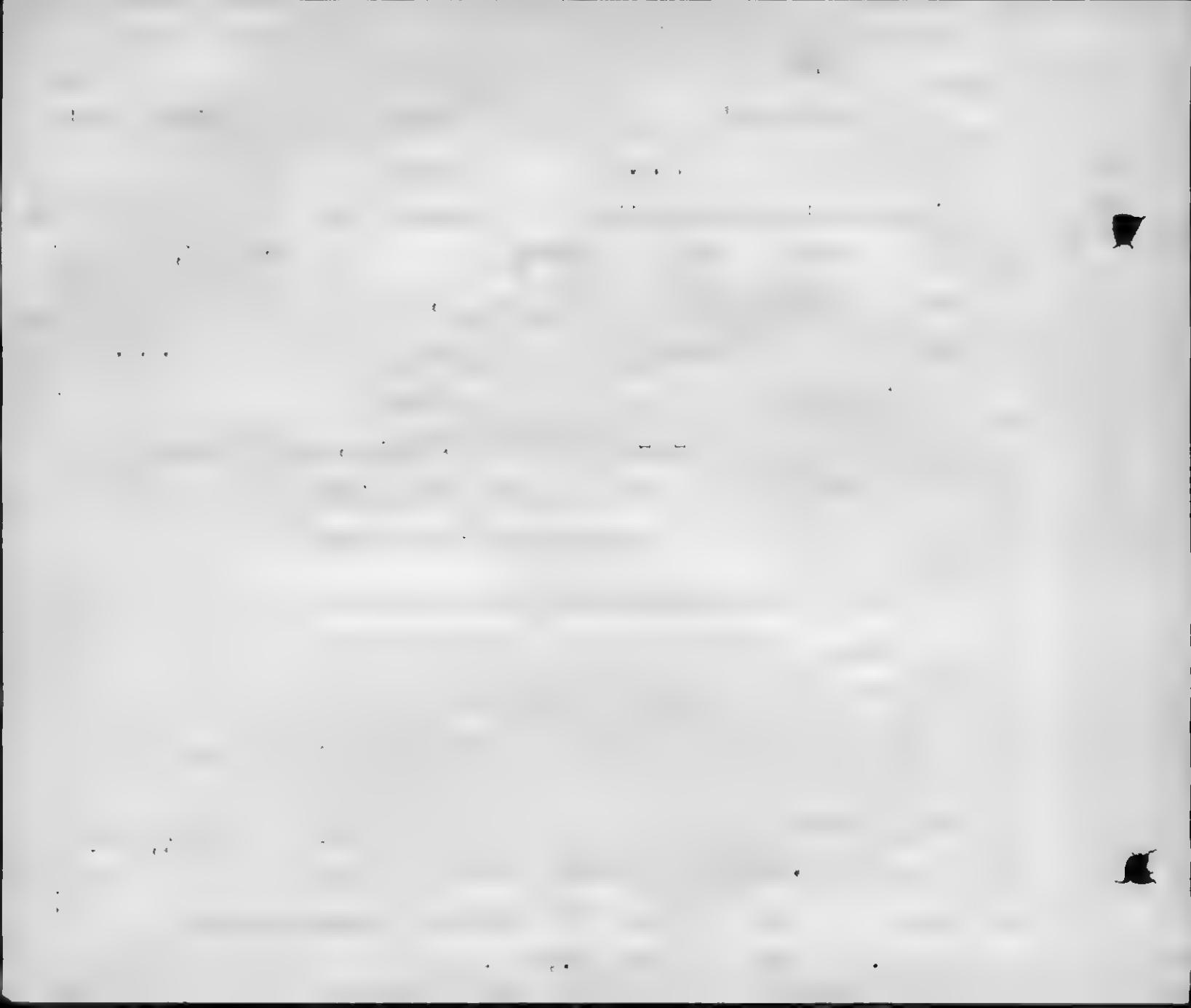
Please execute the certificate, writing the word "penciling" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Board of Health, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

839 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08397

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS Brookland Road											
NAME OF DECEASED (Type or print) Edna Marie Snowden		4. DATE OF DEATH Last Month Day Year July 6, 1961	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
5. SEX Female Colored		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1900		9. AGE (in years at birthday) 61 yr.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Fleet		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) No		16. SOCIAL SECURITY NO. 215-26-2499		17. INFORMANT Dorothy J. Snowden, same address as # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Acute congestive heart failure.		INTERVAL BETWEEN ONSET AND DEATH							
		DUE TO (c)		Cardiovascular renal disease									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bowie		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 8, 1861			
EXAMINER'S NAME (Type) James I. Boyd		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-61		22c. NAME OF CEMETERY OR CREMATORIUM Church of Ascension		22d. LOCATION (City, town, or county) Bowie		(State) Md.			
23. FUNERAL DIRECTOR Myrtle K. Rollins 4339 Hunt Pl., N.E.		ADDRESS		24a. REC'D BY REGISTRAR JUL 12 '61		24b. REGISTRAR'S SIGNATURE Charles S. Knott							
VS. ATSM 5M 9/60													



FOR STATE
HEALTH DEPT.

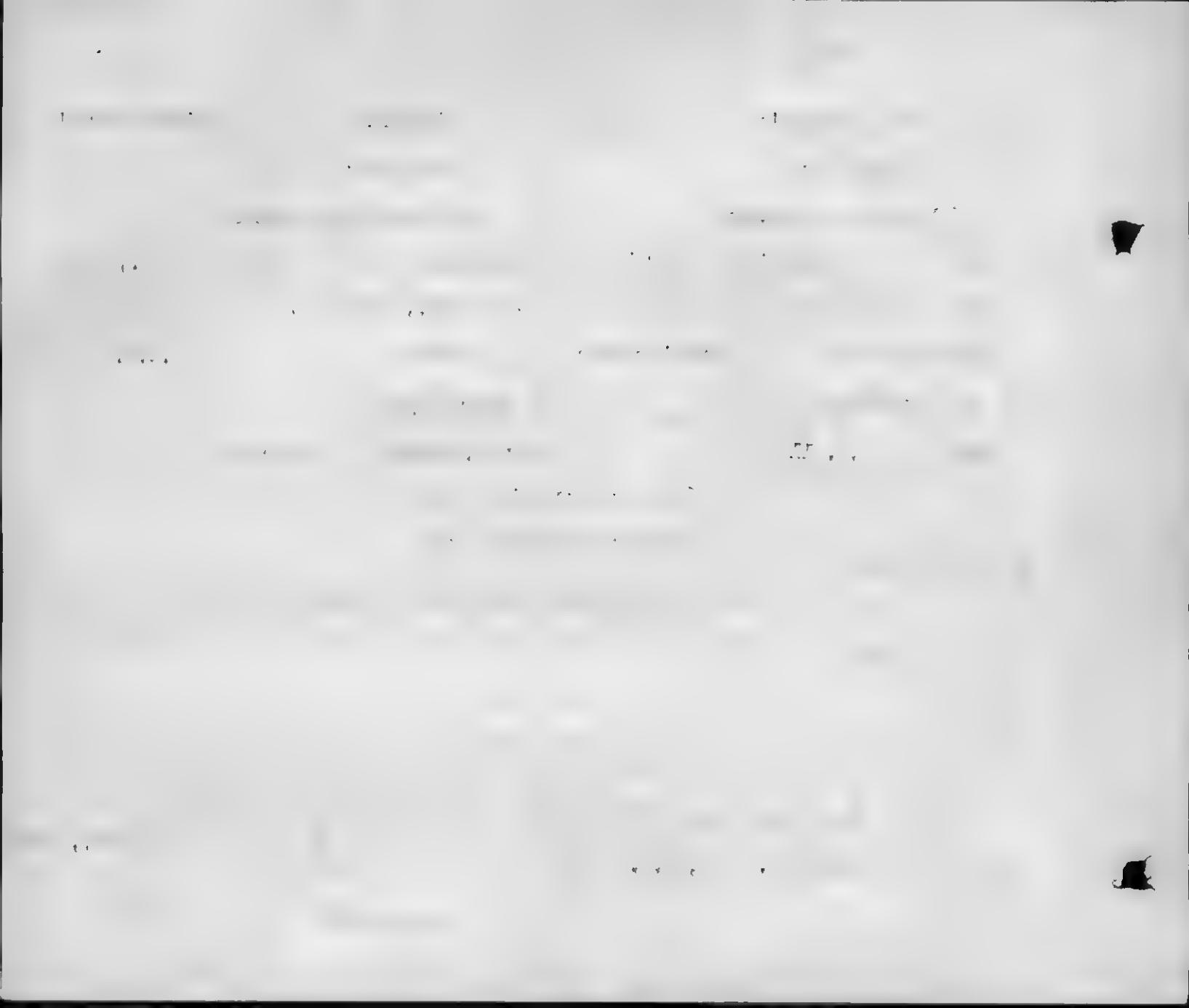
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
840 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08394

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takomo Park		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takomo Park		d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 410 Ethan Allen Avenue		First	Middle	Last	Month	Day	Year				
3. NAME OF DECEASED (Type or print) Martin Greig		4. DATE OF DEATH July 14th., 1961		5. SEX Male		6. COLOR OR RACE White					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 3rd., 1904		9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lyntype operator		10b. KIND OF BUSINESS OR INDUSTRY Evening Star		11. BIRTHPLACE (State or foreign country) Canada		12. IF UNDER 24 HRS. Hours Min.					
13. FATHER'S NAME Arthur Steele		14. MOTHER'S MAIDEN NAME Clara Tryon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give rank or date of service) W.W. II		16. SOCIAL SECURITY NO. Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO		Coronary occlusion.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE James S. Boyd		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 110 Locust Cemetery		DATE SIGNED July 14th., 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17-1961		22c. NAME OF CEMETERY OR CREMATORIUM 110 Locust Cemetery		22d. LOCATION (City, town, or country) Prince George's Md.		24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
23. FUNERAL DIRECTOR Arthur Teller		ADDRESS 351 Carroll St.		24c. DATE JUL 17 '61							

IN JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08395

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		d. STREET ADDRESS Route 1 Box 750		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Baby Girl		First	Middle	Last	4. DATE OF DEATH Stetler	Month July	Day 5	Year 1961
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 5, 1961	9. AGE (In years last birthday) — yrs	10. IF UNDER 1 YEAR Months —	11. IF UNDER 24 HRS Days 52	12. IF UNDER 24 HRS Hours 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cheverly, Maryland		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Lewis Edward Stetler		14. MOTHER'S MAIDEN NAME Mary Sugart						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town)		(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from July 5, 1961 to July 5, 1961 , that (I) (we) last saw the deceased alive on 7/5 1961 and that death occurred at 1801 Eye St. N.W. from the causes and on the date stated above.								
22a. SIGNATURE Frank Harlan		M.D.		ATTENDING PHYS Frank Harlan	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED July 5, 1961	
22c. PHYSICIAN'S NAME (Type) F. I. Harlan MD		22d. ADDRESS 1801 Eye St. N.W.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/22/61		23c. NAME OF CEMETERY OR CREMATORIAL Prince Geo. Gen. Hospital		23d. LOCATION (City, town, or county) Cheverly, Md.		(State)
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn Jr.		ADDRESS		25a. REC'D BY REGISTRAR Arthur S. Kraus		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		
				DATE July 24 '61				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08396

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST HEIGHTS c. LENGTH OF STAY IN 1b 4 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FOREST HEIGHTS . Md. 15	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS 104 Woodland DR.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CARRIE Middle ELIZABETH STEVENS Last		4. DATE OF DEATH Month July Day 20 Year 1961	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 Aug. 1882 9. AGE (In years lost birthday) 78 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) D.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PHILLIP WISTER		14. MOTHER'S MAIDEN NAME Margaret Ballinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO no 17. INFORMANT Evelyn Forest Address Forest Hts. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 114.5X DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hypertensive Heart Disease (c) DUE TO Atherosclerosis.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour p.m. 19		20d. INJURY OCCURRED While at Work <input type="checkbox"/> Not while at Work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 10, 1955</u> , to <u>July 19, 1961</u> , that I last saw the deceased alive on <u>July 19, 1961</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>M.D. 3800 S. Capitol St. Wash. 20, D.C. 20, July 1961</u> DATE SIGNED <u>MAX E. FELDMAN M.D.</u>	
ACTUAL SIGNATURE <u>MAX E. FELDMAN M.D.</u>		22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7-24-61</u> 22c. NAME OF CEMETERY OR CREMATOR Y <u>Fort Lincoln</u> 22d. LOCATION (City, town, or county) <u>Bladensburg</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Semmyne Bros.</u>		24a. REC'D BY REGISTRAR ADDRESS <u>1661 Good Hope Rd SE</u> DATE JUL 24 '61 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8403 8397

1. PLACE OF DEATH a. COUNTY		1. CMS 15 & 1st inf		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Prince Georges Co.		MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 hrs		Maryland Howard	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Prince Georges General Hospital		Brown Bridge Road			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year
Bruce Baby Calvin	Bo		Stockman, Jr.	July 14	1961
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
Male	White		13 July 1961	2	2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or Foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Bruce Calvin St. Ckln			14. MOTHER'S MAIDEN NAME Peggy Ann Wedde		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
Preexisting					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 13 1961 to July 13 1961 that (I) (we) last saw the deceased alive on July 13 1961 and that death occurred 12 PM from the causes and on the date stated above					
22a. SIGNATURE Dr. Labarraqe, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Labarraqe, M.D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/21/61		23c. NAME OF CEMETERY OR CREMATORIAL Prince Geo. Gen. Hospital	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus		ADDRESS 1723 M St., N.W., Washington 6, D.C.		25a. REC'D BY REGISTRAR DATE JUL 24 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

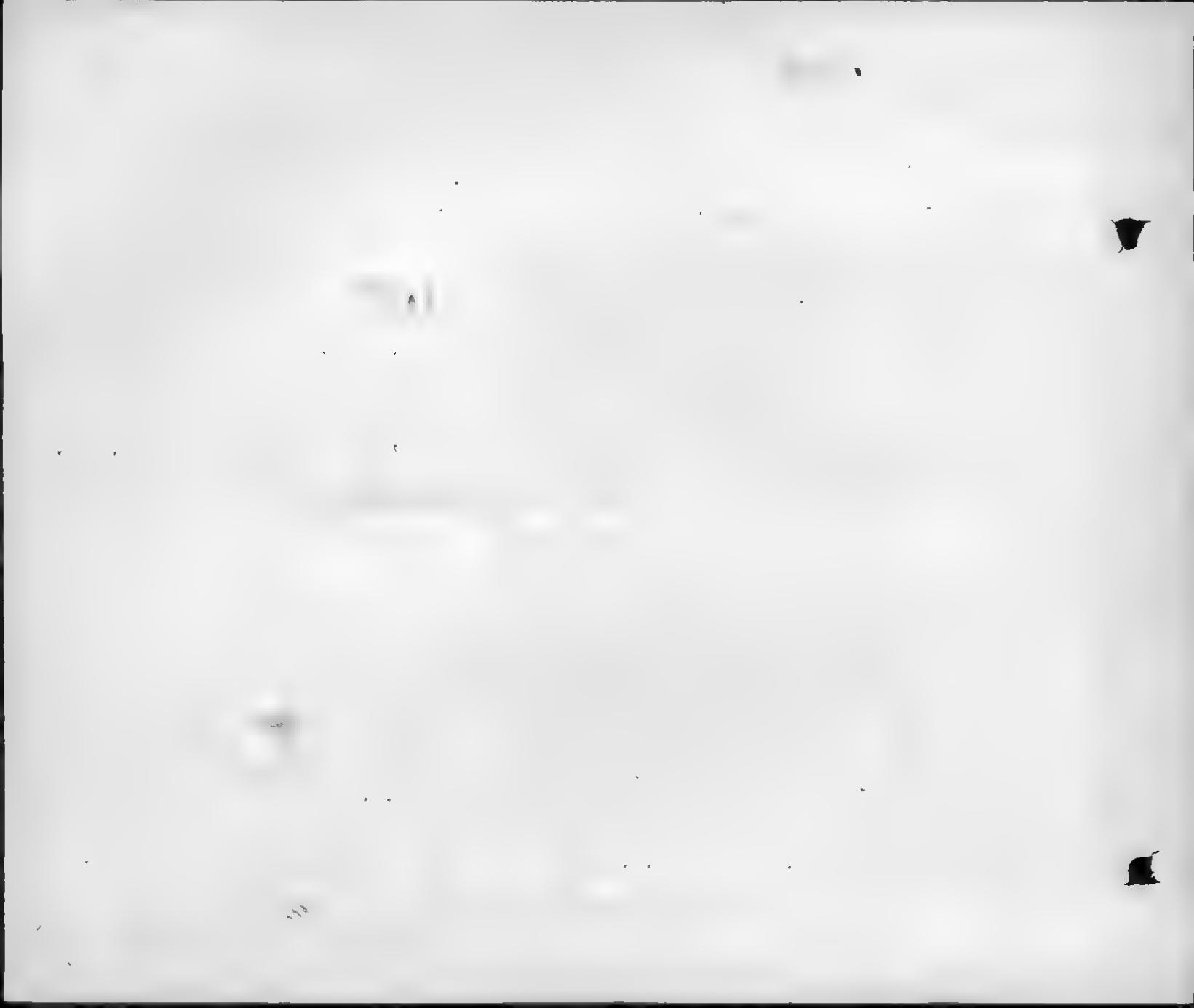
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08398

1 PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights		d. STREET ADDRESS 910-64th Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Waver	Middle	Last Sumpter	4. DATE OF DEATH July 25	Month	Day	Year 1961
5 SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1897	9. AGE (In years last birthday) 64 yrs	10. IF UNDER 1 YEAR Months 910-64th Avenue	11. IF UNDER 24 HRS Days Santee, S.C.	12. IF UNDER 24 HRS Hours Min. USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Santee, S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roland Grayton (Dec)		14. MOTHER'S MAIDEN NAME Elizabeth ? (Dec)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Wade Sumpter, Son, Cedar Heights, Md.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage Generalized Artherosclerosis				
						INTERVAL BETWEEN ONSET AND DEATH 4 days	
						INTERVAL BETWEEN ONSET AND DEATH 4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 21 Jul 61 to 25 Jul 61 , that (we) last saw the deceased alive on 25 Jul 61 , and that death occurred at 7:20A , from the causes and on the date stated above.		22e. SIGNATURE Thomas G. Maloney		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22f. DATE SIGNED 25 Jul 61	
22c. PHYSICIAN'S NAME (Type) Thomas G. Maloney, M.D.		22d. ADDRESS 4814 71st Avenue, Landover Hills, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify) July 30, 1961		23b. DATE THEREOF July 30, 1961		23c. NAME OF CEMETERY OR CREMATORIUM Church Cemetery		23d. LOCATION (City, town or county) Santee SC	
24. FUNERAL DIRECTOR'S SIGNATURE L. Murray Wilson		ADDRESS 1337 10th St. N.W.		25a. REC'D BY REGISTRAR DATE 167 JUL 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



1
FOR STATE
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

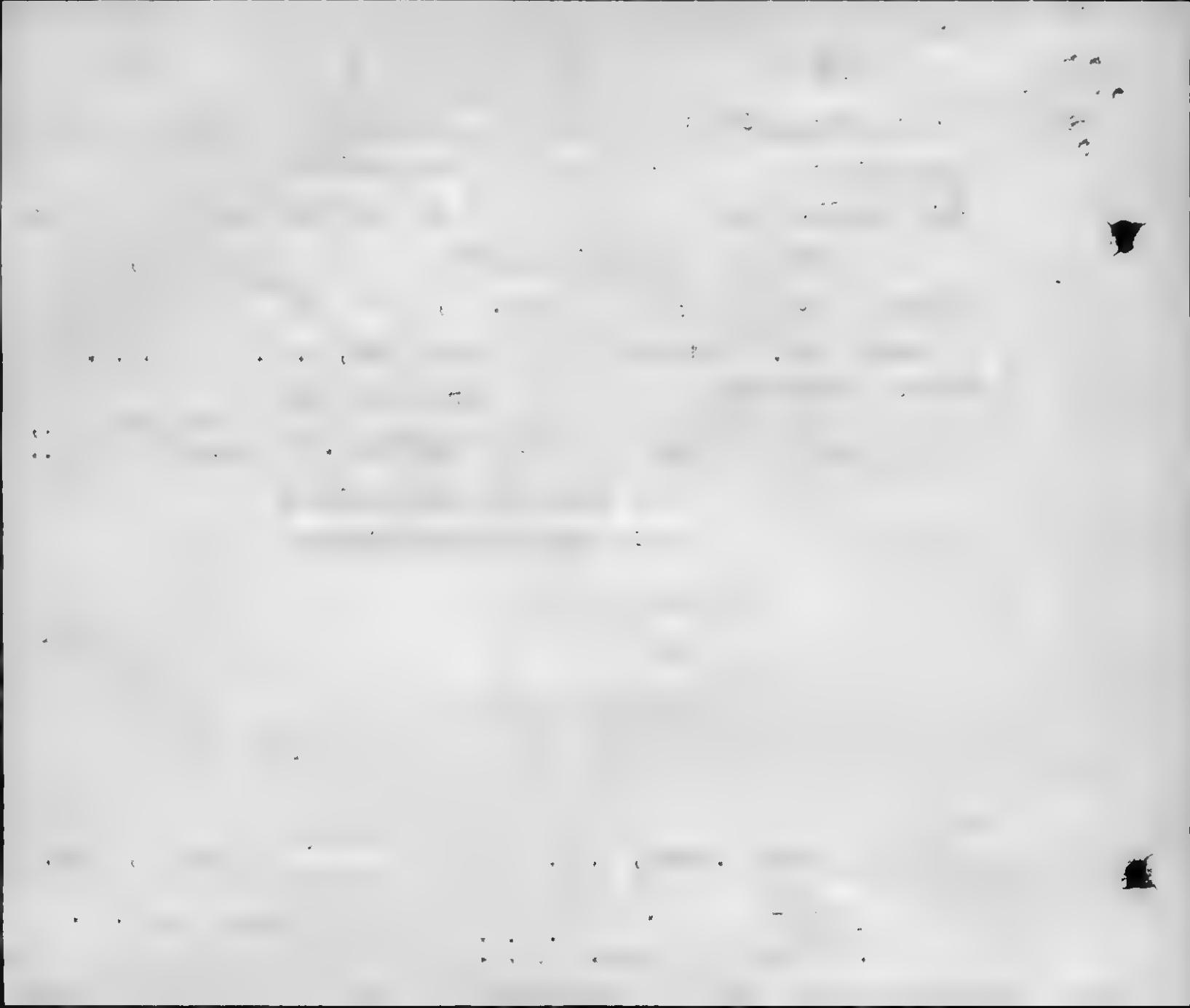
8405 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00393

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
Prince Georges County MARYLAND		a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Hyattsville 18 months		c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4922 LaSalle Road		d. STREET ADDRESS 4922 LaSalle Road	
3. NAME OF DECEASED (Type or print) MARY FLORENCE TASTET		4. DATE OF DEATH Last Month Day Year July 19, 1961	
5. SEX Female White 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21, 1874	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Ret.		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		9. AGE (In years last birthday) IF UNDER 1 YEAR 86 yrs. Months Days Hours Min. IF UNDER 24 HRS.	
13. FATHER'S NAME Robert Joseph Dawson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank or dates of service) No None		16. SOCIAL SECURITY NO. 17. INFORMANT None Waldo Tastet Sr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address 7021 Pyle Rd., Bethesda 14, Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 412 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Acute Congestive Heart Failure Cardio Vascular Renal Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While Not While p.m. at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
ACTUAL SIGNATURE JAMES I. BOYD, M. D.		DATE SIGNED July 19, 1961.	
EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7-22-61 22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery 22d. LOCATION (City, town, or country) Washington D. C.	
23. FUNERAL DIRECTOR FRANCIS J. COLLINS 3821 14th. St. N.W.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE ADDRESS Wash. D.C. DATE JUL 24 '61 Wilmer S. Kraus	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8405

CERTIFICATE OF DEATH

08400

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

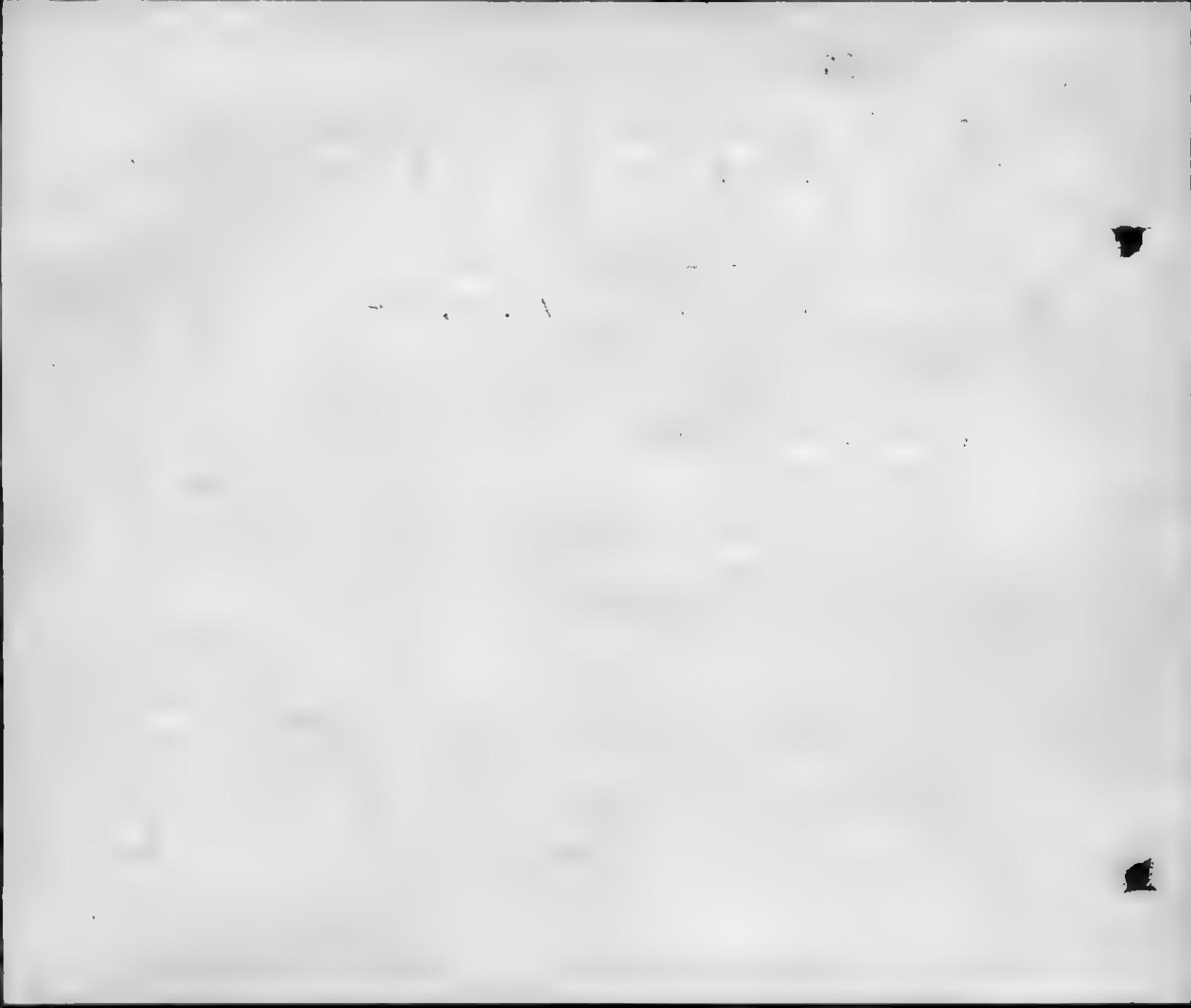
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND	2. USUAL RESIDENCE [Where deceased lived, if institution, Residence before admission] b. STATE MARYLAND DR. GEO'S.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-CLINTON	c. LENGTH OF STAY IN lb 40 YRS X RURAL-CLINTON				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Box 635	d. STREET ADDRESS 1 RT, Box 635				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RT, Box 635	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) NORA CECILIA THORNE	4. DATE OF DEATH Last Month Day Year JULY 3 1961				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Aug. 22, 1884	8. DATE OF BIRTH 76 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY FARM	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HENRY KING	14. MOTHER'S MAIDEN NAME ADELAIDE WHITE SON -	Address Bryans Reed Maryland			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> YES NO	16. SOCIAL SECURITY NO. None	17. INFORMANT SON - WILLIAM E. THORNE JR.	INTERVAL BETWEEN ONSET AND DEATH 15 MIN.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) DUE TO CEREBRO-VASCULAR ACCIDENT					
ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE 10YRS.					
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ACUTE PYELONEPHRITIS - 2 DAYS					
20a. ACCIDENT WAS AN UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner.) NONE	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	20c. TIME OF INJURY Month, Day, Year Hour AM P.M. NONE	20d. INJURY OCCURRED While at work NONE	20e. PLACE OF INJURY Home, farm, factory, street, office, etc. NONE	20f. (City or town) (County) (State) NONE
21. I certify that (I) (Not Hospital) attended the deceased from SEPT 10 1961 , and that death occurred at 11 PM , from the causes and on the date stated above.	22. SIGNATURE <i>Arthur Shaver Jr.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS ARTHUR SHAVER JR. M.D., BRANCH AVE, CLINTON, MD.	22b. DATE SIGNED 9/3/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 6-61	23b. DATE THEREOF July 6-61	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill	23d. LOCATION (City, town or county) (State) Saint Paul, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Summons Bus 1661-4d Roger Rd & E. Dr</i>	ADDRESS West.	25a. REC'D BY REGISTRAR DATE JUL 5 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kline		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8407

8401

1. PLACE OF DEATH
a. COUNTY

Prince George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

MARYLAND

c. LENGTH OF STAY IN lb

6 Days

d. NAME OF HOSPITAL OR INSTITUTION (If no. in hospital, give street address)

Prince George General Hospital

3. NAME OF
DECEASED
(Type or print)

Ruth

First

Middle

J.

5. SEX

Female

6. COLOR OR RACE

Colored

7. MARRIED

X

NEVER MARRIED

8. DATE OF BIRTH

Tibbs

Last

Month

Day

Year

July

29

1961

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook

13. FATHER'S NAME

Russell Jarrett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or grade of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

231 22 8851

Reese Tibbs 7251 Booker Dr., Wash. 27, D.C.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Intestinal Obstruction due to Paralytic Ileus
DUE TO Diabetes Mellitus, uncontrolled

INTERVAL BETWEEN
ONSET AND DEATH

48 hours

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b) Pyosalpinx, right

DUE TO Submucous leiomyofibroma of uterus

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.e.)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING LI
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While Not White
p.m. at work at work

20d. INJURY OCCURRED
While Not White
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)
(State)

21. I certify that (this hospital) attended the deceased from July 23, 1961 to July 29, 1961 that (we) last saw the deceased alive on July 29, 1961, and that death occurred at 11:15A.M. from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Francis X. Carillo, M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

7/33/61

1013 University Blvd. Silver Spring

23a. BURIAL, CREMATION
REMOVAL (Specify)

Burial

8-2-61

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

Arlington National

23d. LOCATION (City, town or county)

Arlington, Va.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

K. Rollins

ADDRESS

Rollins Funeral Home 4339 Hunt Pkwy

25a. REC'D BY REGISTRAR

AUG 2 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



FOR STATE
HEALTH DEPT.

M

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8408 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08402

1. PLACE OF DEATH
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

BOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
DECEASED
(Type or print)

Stanton

Edward

Tippett

4. SEX
Male

5. COLOR OR RACE
White

6. MARRIED
WIDOWED

NEVER MARRIED
DIVORCED

7. DATE OF BIRTH

June 2, 1915

8. DATE OF
DEATH

Last Month Day Year

July

4,

1961

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cab Driver

10b. KIND OF BUSINESS OR INDUSTRY

Transportation

11. BIRTHPLACE (State or foreign country)

District of Columbia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Clarence Edward Tippett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or grade of service)

Yes WWI

16. SOCIAL SECURITY NO.

17. INFORMANT

579-05-8402 Marguerite Tippett, same as #2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Asphyxia

INTERVAL BETWEEN
ONSET AND DEATH

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

Drowning

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Drowning in the potomac river

20c. TIME OF INJURY Month, Day, Year
2:30 pm 7/4 61

20d. INJURY OCCURRED

While at work

Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

River

20f. (City or town)

Oxon Hll

(County)

Prince George, Md (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

7/4/61

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

James I. Boyd

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

7-7-61

22c. NAME OF CEMETERY OR CREMATORI

Arlington Natl. Cem.

22d. LOCATION (City, town, or country)

Arlington, Virginia

(State)

23. FUNERAL DIRECTOR

W. W. Chambers Co Riverdale, Md

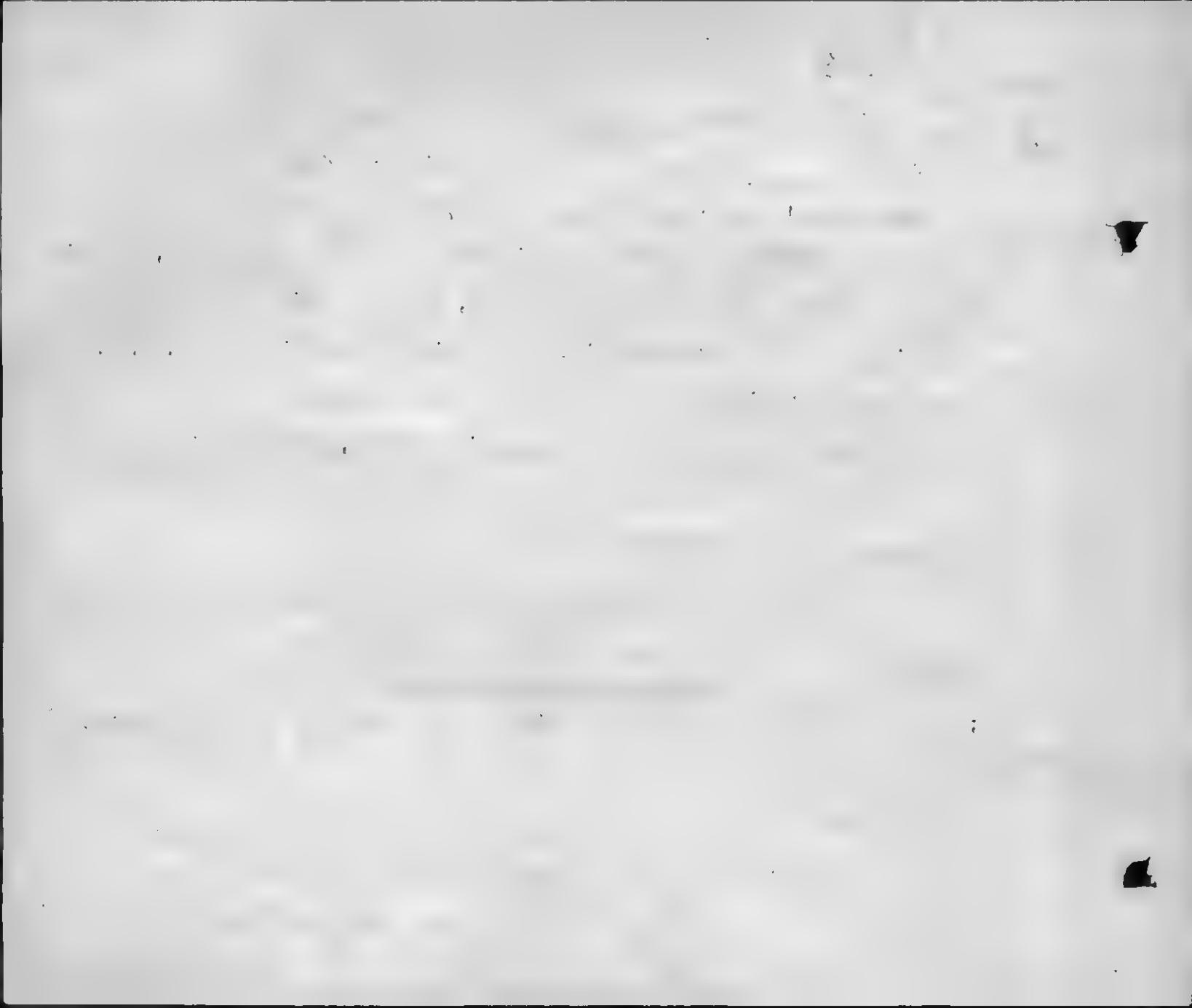
24a. REC'D BY REGISTRAR

JUL 10 '61

DATE

24b. REGISTRAR'S SIGNATURE

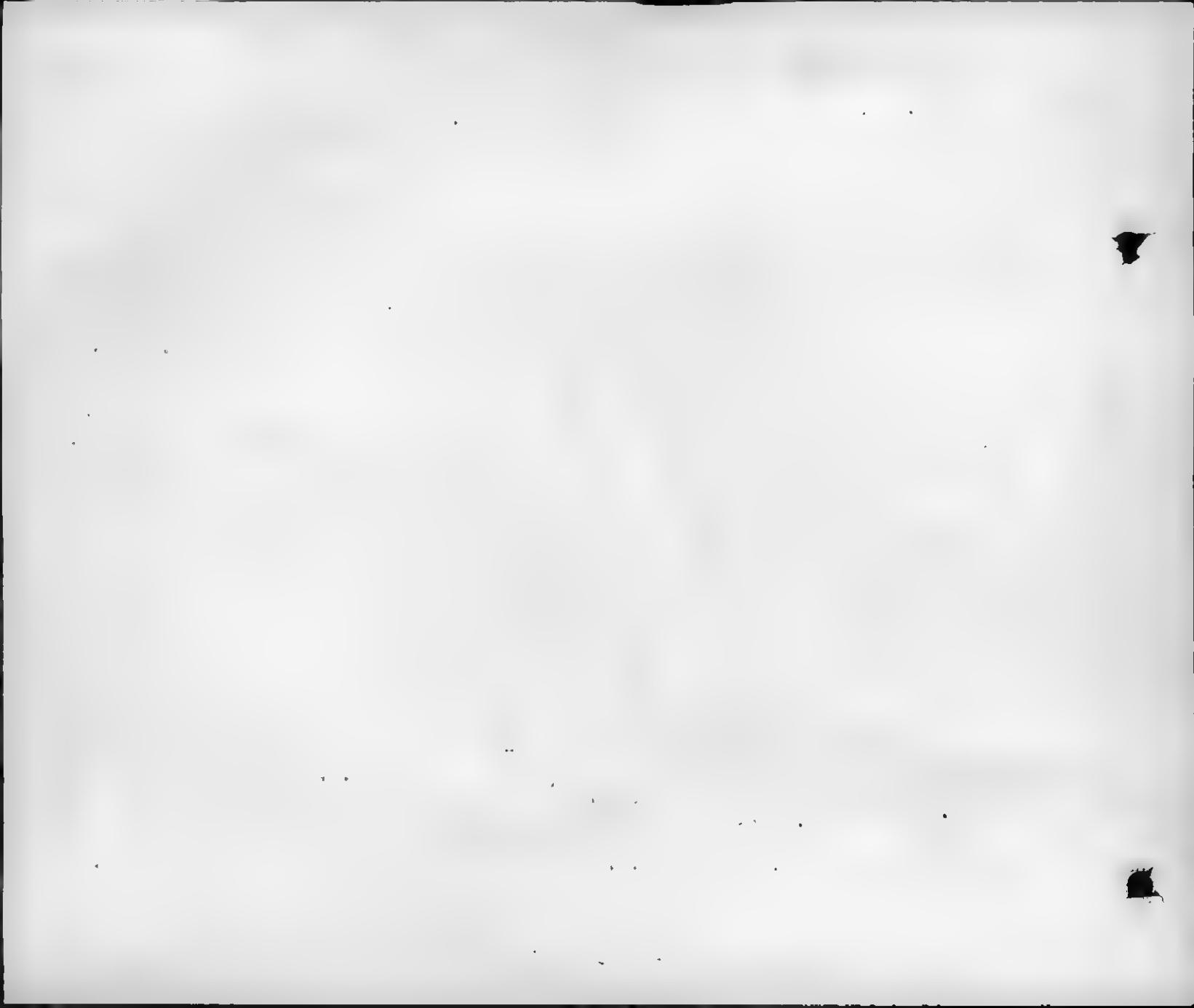
Arthur S. Knoll



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
8409		Item 9 File 0291								88403			
1. PLACE OF DEATH a. COUNTY		Prince George		MARYLAND		12 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Cheverly		c LENGTH OF STAY IN 1b		Md.		Prince George					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Prince George General		51 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Takoma Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Fannie		Middle		Last Turner		4. DATE OF DEATH		Month July 15 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS			
Female		C				June 1, 1919		42 1/2 yrs		Months Days Hours Min.			
10a. JST AL OCCUPAT ON (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?							
		Housewife		Columbus, Georgia		U. S. A.							
13. FATHER'S NAME		James Powell		14. MOTHER'S MAIDEN NAME		Minnie Gibson		Address		Silver Sprin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT		Joseph Turner		7105 N. H. Ave.		Md.			
no		none											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a))		DUE TO Uremia											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X		DUE TO Hypertensive Cardiovascular Renal Disease											
(b) DUE TO		years											
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19				May									
21. I certify that (I) (this hospital) attended the deceased from <u>May 25, 1961</u> to <u>July 15, 1961</u> , that (II) (we) last saw the deceased alive on <u>July 15, 1961</u> , and that death occurred at <u>9:50 P.M.</u> List the causes and on the date stated above.													
22a. SIGNATURE William D. Rosson, M.D.		ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/16/61					
22c. DIRECTOR'S NAME (Type) William D. Rosson, M.D.		22d. ADDRESS 5701 85th Avenue, Carrollton, M.D.											
23a. BURIAL, CREMATION REMOVAL (Specify) 7/17/61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL Baldwin & White Funeral ADDRESS		23d. LOCATION (City, town, or county) Columbus, Georgia		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE Alex S. Rose Jr.		414-15th St. SE		H-25 REC'D BY REGISTRAR DATE JUL 18 '61		25b. REGISTRAR'S SIGNATURE Albert S. Stevens							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

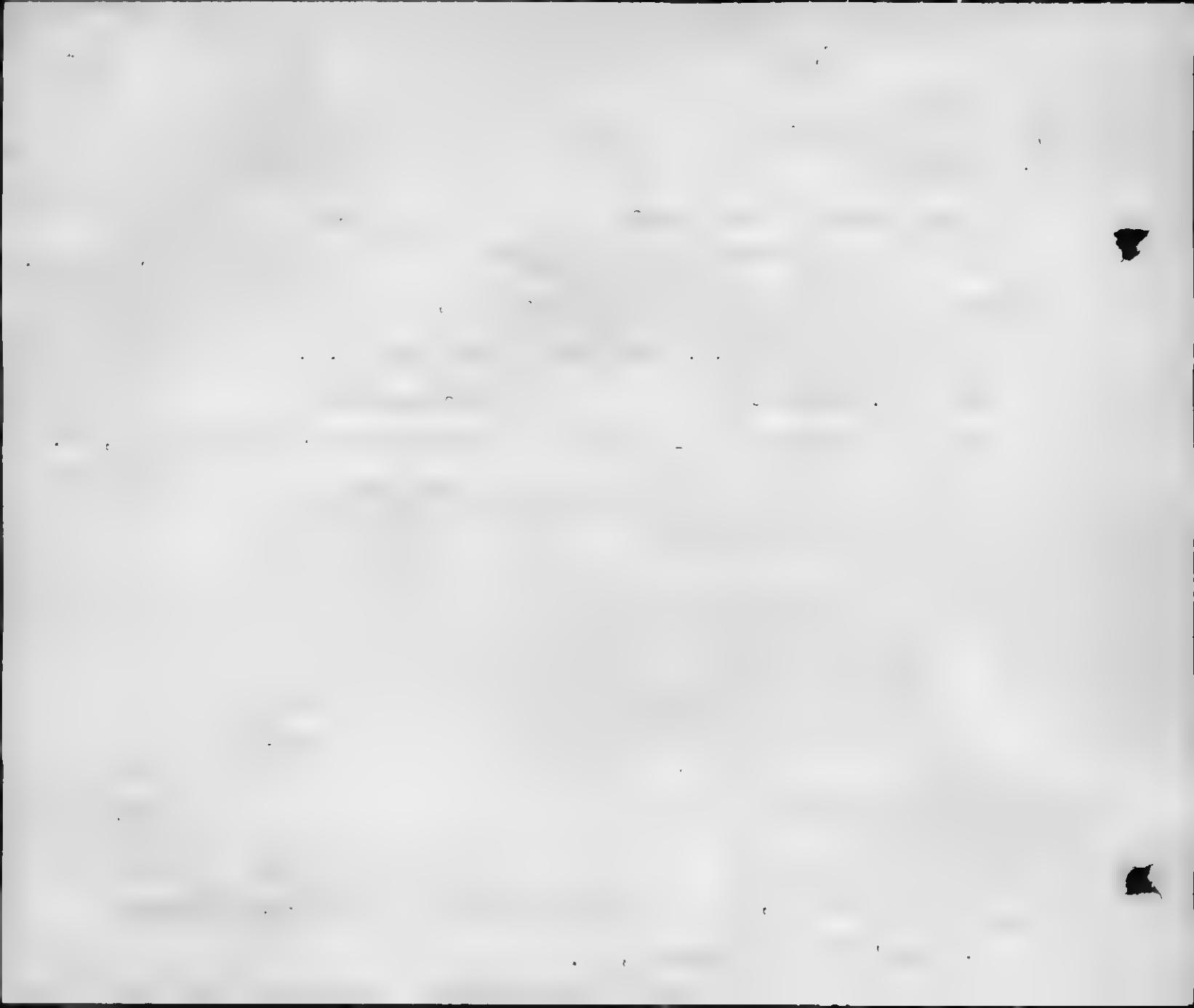
8410

C8405

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH e. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Prince George		a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		b. COUNTY Prince George	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		c. LENGTH OF STAY IN MONTHS	
3. NAME OF DECEASED (Type or print)		First	Middle
Male		Kenneth	S
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ordnance		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles E. VanFleet		14. MOTHER'S MAIDEN NAME Emma Galloway	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Yes		16. SOCIAL SECURITY NO. 17. INFORMANT	
WW II		004-24-8269 Elizabeth N Van Fleet	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. INTERVAL BETWEEN ONSET AND DEATH	
162.1 Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)		multiple stab embalmed at 1st Brown & Son's Casket Co. St Louis	
} DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/23, 1961, to 7/7, 1961, that (I) (we) last saw the deceased alive on 7/6, 1961, and that death occurred at _____ M, from the causes and on the date stated above.		22b. DATE SIGNED July 7, 1961	
22a. SIGNATURE Julius Kauffman		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Julius Kauffman		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 11, 1961	
23c. NAME OF CEMETERY OR Crematory Arlington National		23d. LOCATION (City, town or county) Arlington Virginia (State)	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE JUL 13 '61		25b. REGISTRAR'S SIGNATURE Cathleen S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

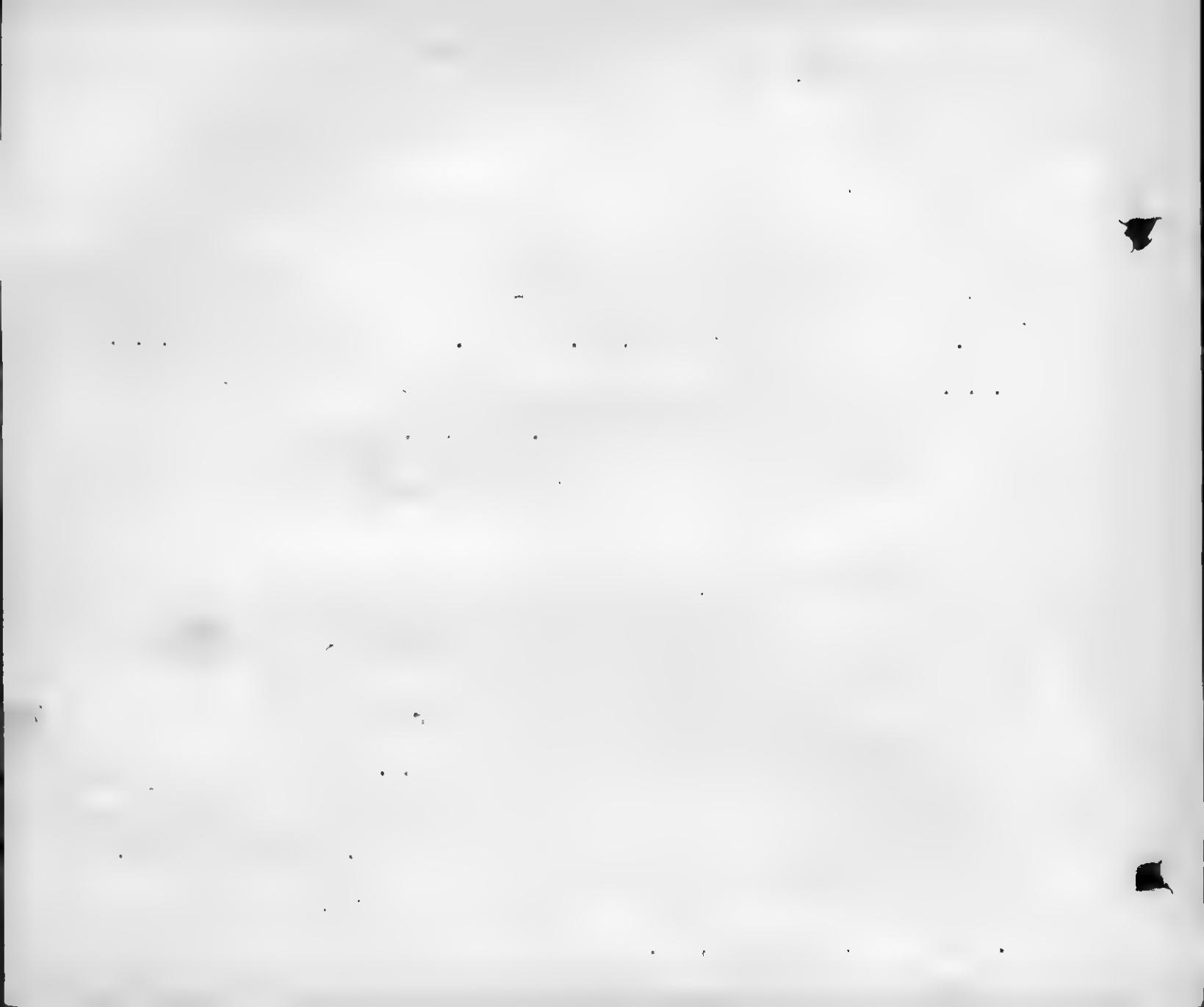
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08405

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN lb 6 days	b. COUNTY Prince George's	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cottage City
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General		d. STREET ADDRESS 3708 38th Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Paul	Middle C	Last Wallin
4. DATE OF DEATH 7-27-61	Month 7	Day 27	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-23-82
9. AGE (In years last birthday) 79 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ins. Agent	11. KIND OF BUSINESS OR INDUSTRY Life Ins. Co.	12. BIRTHPLACE (State or foreign country) Ill.
13. CITIZEN OF WHAT COUNTRY? U.S.A.	14. MOTHER'S MAIDEN NAME Louisa Mithilda Erickson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO 349032515	17. INFORMANT Mrs. Elvira W. Greenwood	Address Same as # 2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Deceased had Edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Underlying heart disease</i> DUE TO (c) <i>Heart insufficiency</i>			
INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, 5:30 p.m., from the causes and on the date stated above			
22a. SIGNATURE <i>George Blagage</i>		M.D. ATTENDING MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7-27-61
22c. PHYSICIAN'S NAME (Type) George Blagage		22d. ADDRESS 3717 38th Ave. Cottage City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/31/61	23c. NAME OF CEMETERY OR CREMATORIAL Ceder Hill Cemetery	23d. LOCATION (City, town, or county) Suitland (State) Maryland
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's	ADDRESS Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE JUL 31 '61	25b. REGISTRAR'S SIGNATURE Cirrus S. Thorne



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02405

1. PLACE OF DEATH a. COUNTY <i>Prince Geo.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince Geo.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN lb <i>11 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		d. STREET ADDRESS <i>905 Somerset Pl.</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <i>EDWARD</i>	Middle <i>ERNEST</i>	Last <i>WALTON</i>	4. DATE OF DEATH Month <i>July</i>	Day <i>20</i>	Year <i>1961</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Wh.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 29, 1907</i>		9. AGE (In years last birthday) <i>54</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>5</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Eng'r Inspector.</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
13. FATHER'S NAME <i>Edward Walton</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>				Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>578-09-1425</i>		17. INFORMANT <i>Wife - Mrs. Helen Walton - 905 Somerset Pl.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Arteriosclerotic - lactic heart disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Immed.</i>				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>fall</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6216 N.H. Ave. N.E.</i>	20f. (City or town) <i>Washington, D.C.</i>	(County) <i>D.C.</i>	(State) <i>D.C.</i>
21. I certify that I attended the deceased from <i>June 22, 1961</i> to <i>July 20, 1961</i> , that I last saw the deceased alive on <i>July 17, 1961</i> , and that death occurred at <i>5:20 A.M.</i> from the causes and on the date stated above.		ACTUAL SIGNATURE <i>William F. Simpson, Jr.</i>		M.D.		ADDRESS (Street, city or town, state) <i>6216 N.H. Ave. N.E.</i>		DATE SIGNED <i>7/20/61.</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-24-61</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven</i>		22d. LOCATION (City, town or county) <i>Silver Spring Md.</i>		(State) <i>Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Lewis Sons Co</i>		ADDRESS <i>3605-14 St NW</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 21 '61</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Thomas</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		02407			
8413															
1. PLACE OF DEATH a. COUNTY Prince George's				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 1 day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				d. STREET ADDRESS 4018 Jefferson St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Dora		Middle M		Last Weber		4. DATE OF DEATH July 26 1961		Month Year		Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/16/67		9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Washington D. C.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Augusta Metzler				14. MOTHER'S MAIDEN NAME Doris Schmidt											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address									
no				Mrs. Doris Aman Same as # 2											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arterosclerotic Heart Disease</i>															
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Spurious Arteriosclerosis</i>															
DUE TO (c) <i>Spurious Arteriosclerosis</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 4-1 , 19 29 , to 7-26 , 19 61 , that (I) (we) last saw the deceased alive on 7-26 , 19 61 , and that death occurred at 11:40 from the causes and on the date stated above.															
22a. SIGNATURE <i>C. Reetz Jr.</i>				M.D.		ATTENDING PHYS		P. M. MED DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/29/61		23c. NAME OF CEMETERY OR CREMATORIUM Prospect Hill				23d. LOCATION (City, town, or county) Washington D. C.				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons						ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 31 '61				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 11,810 Ellington Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Clara	Middle L.	Last Weems	4. DATE OF DEATH Month 7	Day 5	Year 1961
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/28/91	9. AGE (In years lost birthday) 69 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) N.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Smith							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Wilma C. Ross - 3520-ClayPl, NE		Address Lock V. Johnson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis, ACUTE INTERVAL BETWEEN ONSET AND DEATH 36 hrs							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease 3 yrs (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/5 1961 to 7/5 1961 , that (I) (we) last saw the deceased alive on 7/5 1961 , and that death occurred on 7/5 1961 at 11:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Norman Donat Comeney		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7/6/61		
22c. PHYSICIAN'S NAME (Type) Norman Donat Comeney		22d. ADDRESS 3503 Penny St NW Washington, DC					
23a. BURIAL, CREMATON, REMOVAL (Specify) Removal		23b. DATE THEREOF 7-10-61		23c. NAME OF CEMETERY OR CREMATORIAL Belair Mem.		23d. LOCATION (City, town, or county) (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington & Sons		ADDRESS 4925 Deane Ave NE		25a. REC'D BY REGISTRAR DATE JUL 11 '61		25b. REGISTRAR'S SIGNATURE	



1
FOR STATE
HEALTH DEPT.

M

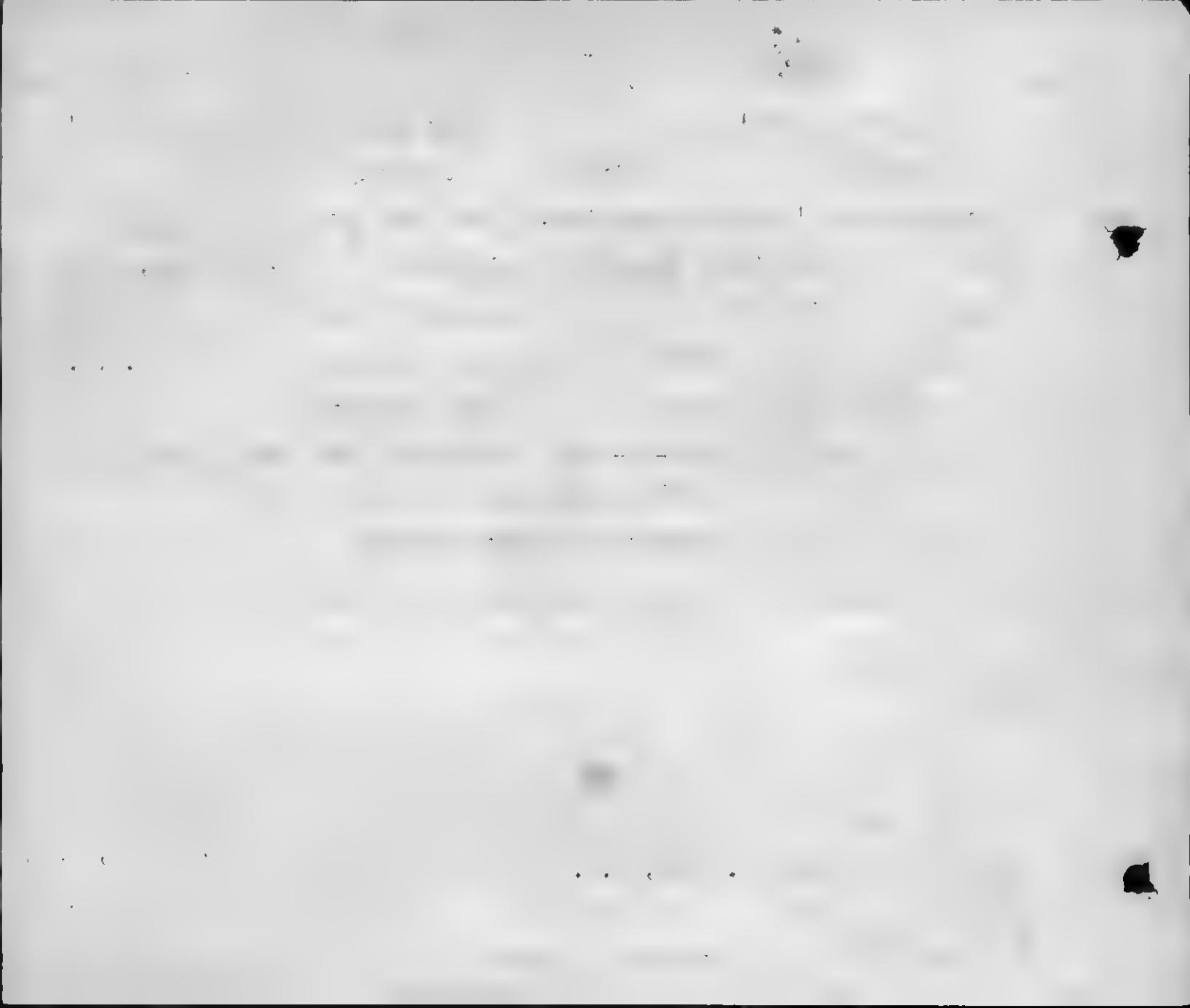
To DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 7 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8415

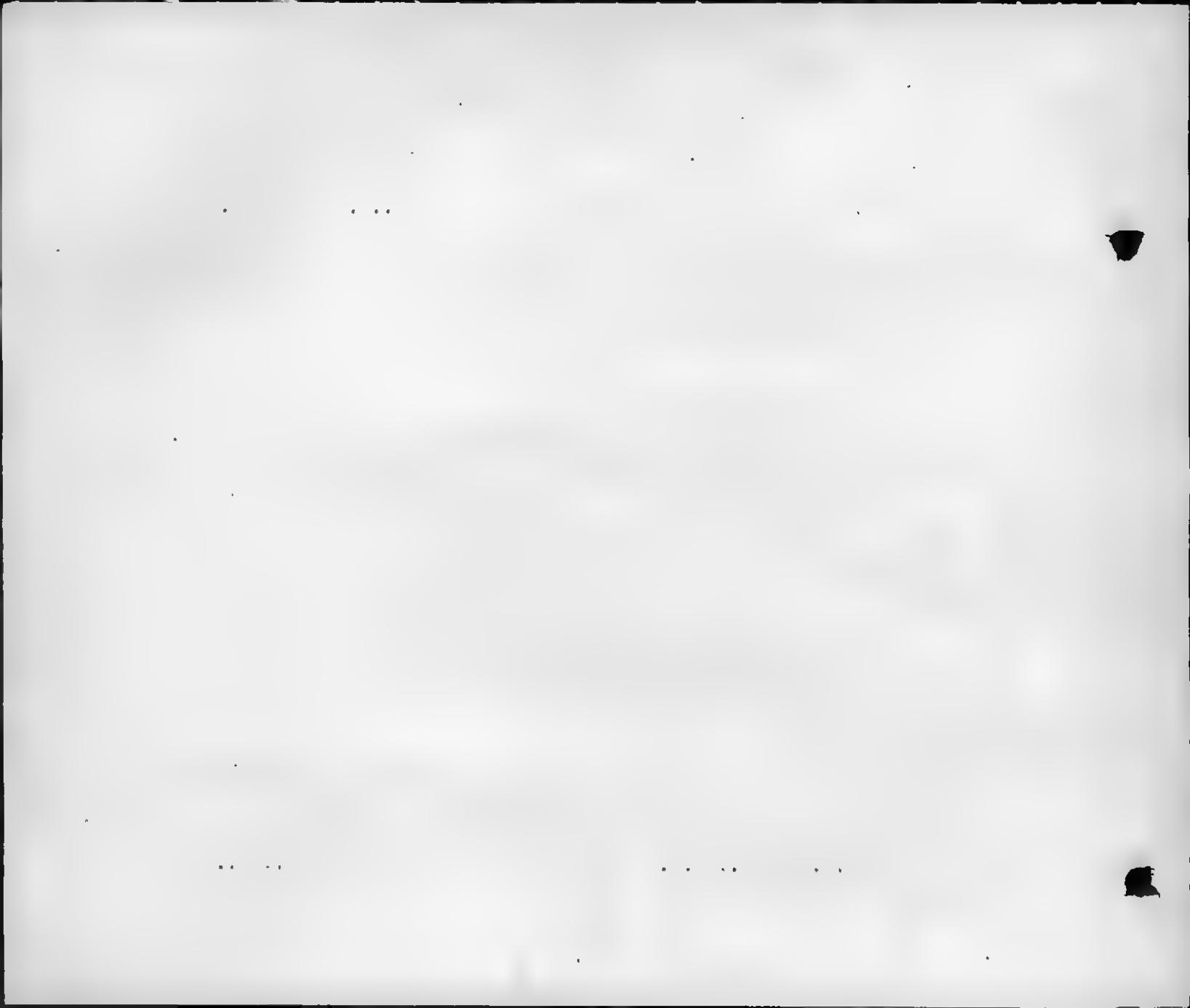
08409

1. PLACE OF DEATH a. COUNTY Prince George's	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	b. COUNTY Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	c. LENGTH OF STAY IN 1b Dead on arrival	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	d. STREET ADDRESS 452
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital	First Francis	Middle Edward	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	4. DATE OF DEATH Last July 31, 1961
8. DATE OF BIRTH August 8, 1904	9. AGE (In years last birthday) Months 56	10. BIRTHPLACE (State or foreign country) Months Penna	11. IF UNDER 1 YEAR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marble setter	10b. KIND OF BUSINESS OR INDUSTRY Unemployed	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edmund L. Weightman	14. MOTHER'S MAIDEN NAME Anna Harris	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give rank and dates of service) No	16. SOCIAL SECURITY NO. 577-09-1014	17. INFORMANT Leona Weightman same as #2	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. } (c)	DUE TO } (b) DUE TO } (c)	Ruptured coronary infarct	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accide. <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James I. Boyd</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/3/61	22c. NAME OF CEMETERY OR CREMATORIUM Ft. Lincoln	22d. LOCATION (City, town, or county) Colmar Manor, Md.
23. FUNERAL DIRECTOR F. Gasch's Sons	ADDRESS Hyattsville, Maryland	24e. REC'D BY REGISTRAR DATE AUG 4 '61	24b. REGISTRAR'S SIGNATURE <i>Henry S. Evans</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		084-0	
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Florida								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 16 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami			d. STREET ADDRESS 8227 N.E. 1st Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital													
3. NAME OF DECEASED (Type or print) Clyde		First	Middle	Last	4. DATE OF DEATH Wells		Month	Day	Year				
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Mar 1890		9. AGE (in years last birthday) 71 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Advertising			11. BIRTHPLACE (State or foreign country) Baltimore, Md			12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME James Wells					14. MOTHER'S MAIDEN NAME ? Peacock								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			16. SOCIAL SECURITY NO.			17. INFORMANT Robert P Wells Hyattsville, Md.			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) S > massive S. I. hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Sabotage caused tear (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 30 AM, from the causes and on the date stated above.													
22a. SIGNATURE <i>A. Deitz, M.D.</i>					M.D. <input type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> 22b. DATE SIGNED July 4, 1961		MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) Dr. A. Deitz., M.D.					22d. ADDRESS Hyattsville, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 7/6/61			23b. DATE THEREOF 7/6/61			23c. NAME OF CEMETERY OR CREMATORIAL Auburn			23d. LOCATION (City, town, or county) New York				
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons					ADDRESS Hyattsville, Md.			25a. REC'D BY REGISTRAR JUL 10 '61		25b. REGISTRAR'S SIGNATURE <i>John G. Kline</i>			



1
FOR STATE
HEALTH DEPT.



delay is necessary,
please forward to the General Director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 290 7-12

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8417 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08411

1. PLACE OF DEATH	Item 1f & 1g Infor. From Death		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. COUNTY	Prince George's		b. STATE Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince George's
c. LENGTH OF STAY IN 1b	MARYLAND		d. STREET ADDRESS Brandywine
3. NAME OF DECEASED (Type or print)	Prince George's General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
4. DATE OF DEATH	Rt. 1 Box 86-E		Month July Day 2 Year 1961
5. SEX	Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH June 30, 1961
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Douglas #1116	14. MOTHER'S MAIDEN NAME Claudia Wills		Address _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank and dates of service)	16. SOCIAL SECURITY NO. 17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Atelectasis to the lungs.	
736.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)		Aspiration to Blood.	
} DUE TO (c)		Faccration to the pharynx	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:30 p.m. 7-1-61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Brandywine (County) P.G. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE James J. Boyd	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) James J. Boyd	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 7/1/61	22c. NAME OF CEMETERY OR CREMATORIY Prince George's Cen. Hosp. Cheverly	DATE SIGNED 7/3/61
23. FUNERAL DIRECTOR Harry W. Pen	ADDRESS	22d. LOCATION (City, town, or country) Va.	(State)
VS. A15ME	5M 7/59	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
HARRY W. PEN		DATE JUL 13 '61	
		A. Shur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If age 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8418

CERTIFICATE OF DEATH

08412

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL		e. STREET ADDRESS 4913 SHELBY DRIVE	
3. NAME OF DECEASED (Type or print) CINDY		First CINDY	Middle ANN
4. DATE OF DEATH JULY 20 1961		Month JULY	Day 20
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH 18 July 1961		9. AGE (In years last birthday) yrs. 1	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
13. FATHER'S NAME AUTHUR B WILSON		14. MOTHER'S MAIDEN NAME DOROTHY LEE CONOVER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and date of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT MEDICAL RECORDS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESP. DISTRESS SYNDROME OF NEWBORN.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PREMATURITY			
DUE TO (b) PREMATURITY			
DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Birth 6 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED Whi a Not Whi a at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that W (this hospital) attended the deceased from 18 JULY 1961 to 20 JULY 1961 , that W (we) last saw the deceased alive on 20 JULY 1961 , and that death occurred at 210A , from the causes and on the date stated above.			
22a. SIGNATURE Arnold A. Abramo		22b. DATE SIGNED 20 JULY 1961	
22c. PHYSICIAN'S NAME (Type) ARNOLD A ABRAMO, Captain USAF MC USAF HOSPITAL, ANDREWS AFB, MARYLAND		M.D. <input type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried July 24, 1961 Belvoir Lane N.E.		23b. DATE THEREOF July 24, 1961	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Belvoir Lane N.E.
24. FUNERAL DIRECTOR'S SIGNATURE Col. Frank J. Wilson, USAF		23d. LOCATION (City, town or county) (State) Belvoir, Md.	
25a. REC'D BY REGISTRAR Arthur S. Kraus		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
DATE JULY 26 '61			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. You may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8419

CERTIFICATE OF DEATH

Item 9 Film 6292 7/2/61 ink

08413

1. PLACE OF DEATH
a. COUNTY

Prince George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN lb

1 day

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
DECEASED
(Type or print)

Calenous

First Middle

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Railroad

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (County & State, or foreign country)

Winfield

13. FATHER'S NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

718-18-7309 Margaret M. Bowles

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN
ONSET AND DEATH

12 hrs

Coronary Thrombosis

Arteriosclerotic Heart Disease

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from June 1958 to July 1961, that (I) (we) last saw the deceased alive on July 25, 1961, and that death occurred at 9 p.m. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

3503 Penny St MT Rainier MD

22b. DATE
SIGNED

7/25/61

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE THEREOF
7-29-61

23c. NAME OF CEMETERY OR CREMATORIUM

Mt Olivet

23d. LOCATION (City, town or county)

Washington D.C.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

J. W. Lee

ADDRESS

300 1/2 ST NW

25a. REC'D BY REGISTRAR
DATE JUL 28 '61

25b. REGISTRAR'S SIGNATURE
Arthur S. Krause

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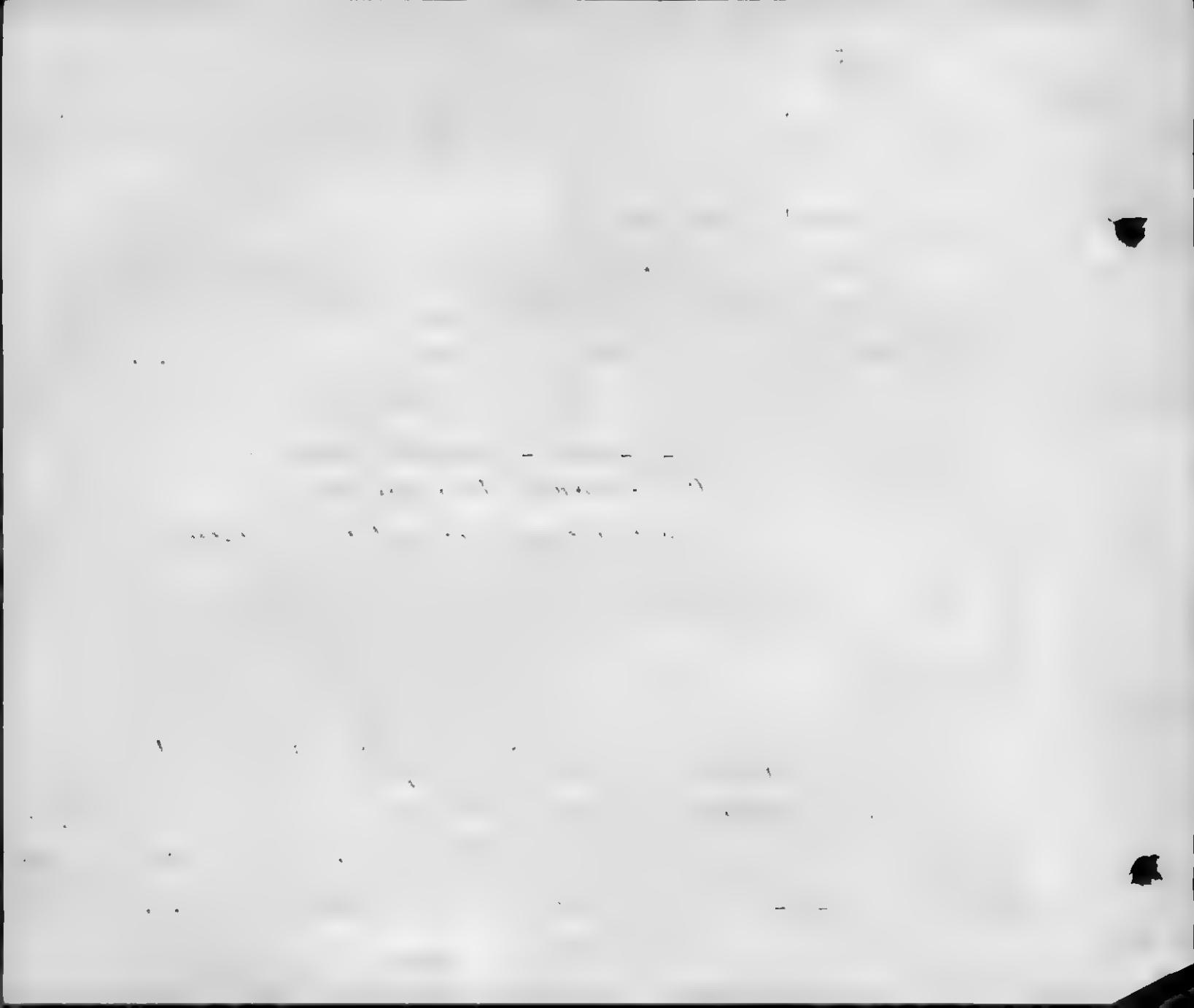
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ge 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M B/60



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FOR STATE
HEALTH DEPT.



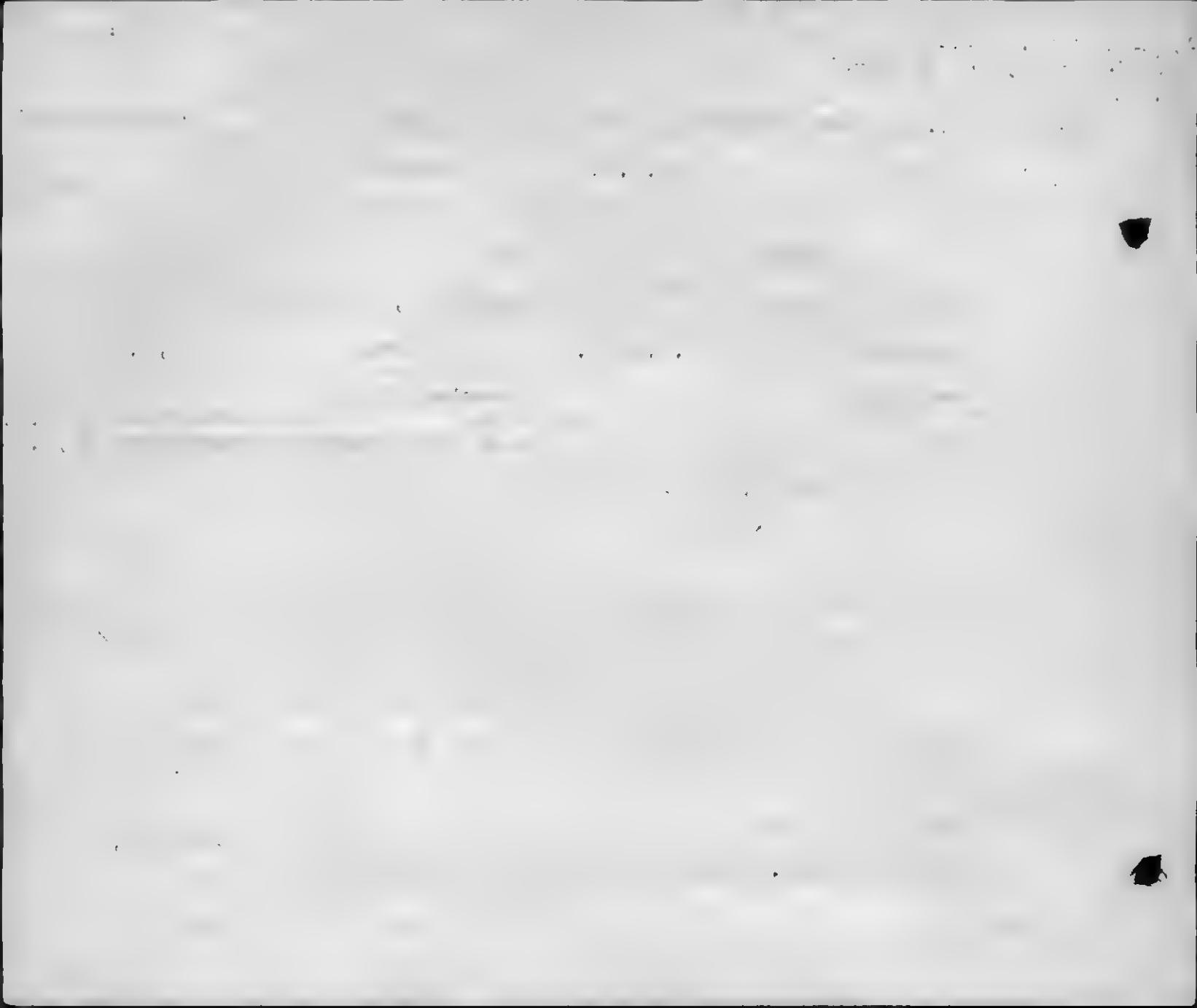
To Deputy Medical Examiner: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 293 8-24

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8420 **08414**

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland Prince George's				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly D.O.A.	c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				
3. NAME OF DECEASED (Type or print) Henry	First Middle				
4. DATE OF DEATH Wohl July 21 1961	Month Day Year				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 8, 1913 48 9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months Days Hours Mins.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist	10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Max Wohl	14. MOTHER'S MAIDEN NAME Bessie Mishel	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or date of service) No	16. SOCIAL SECURITY NO. 17. INFORMANT Helen Wohl Patterson Washington 20, D.D.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) PULMONARY EDEMA					
DUE TO Respiratory Barbiturate poisoning					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
Coronary arteriosclerosis					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> James I. Boyd	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	DATE SIGNED July 21, 1961		
ACTUAL SIGNATURE James I. Boyd	EXAMINER'S NAME (Type) James I. Boyd	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/23/61	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Lebanon Cem.	22d. LOCATION (City, town, or country) Hyattsville Md.
23. FUNERAL DIRECTOR B. DANZANSKY & Sons	ADDRESS Wash. D.C.	24a. REC'D BY REGISTRAR JUL 25 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Krause		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filed in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

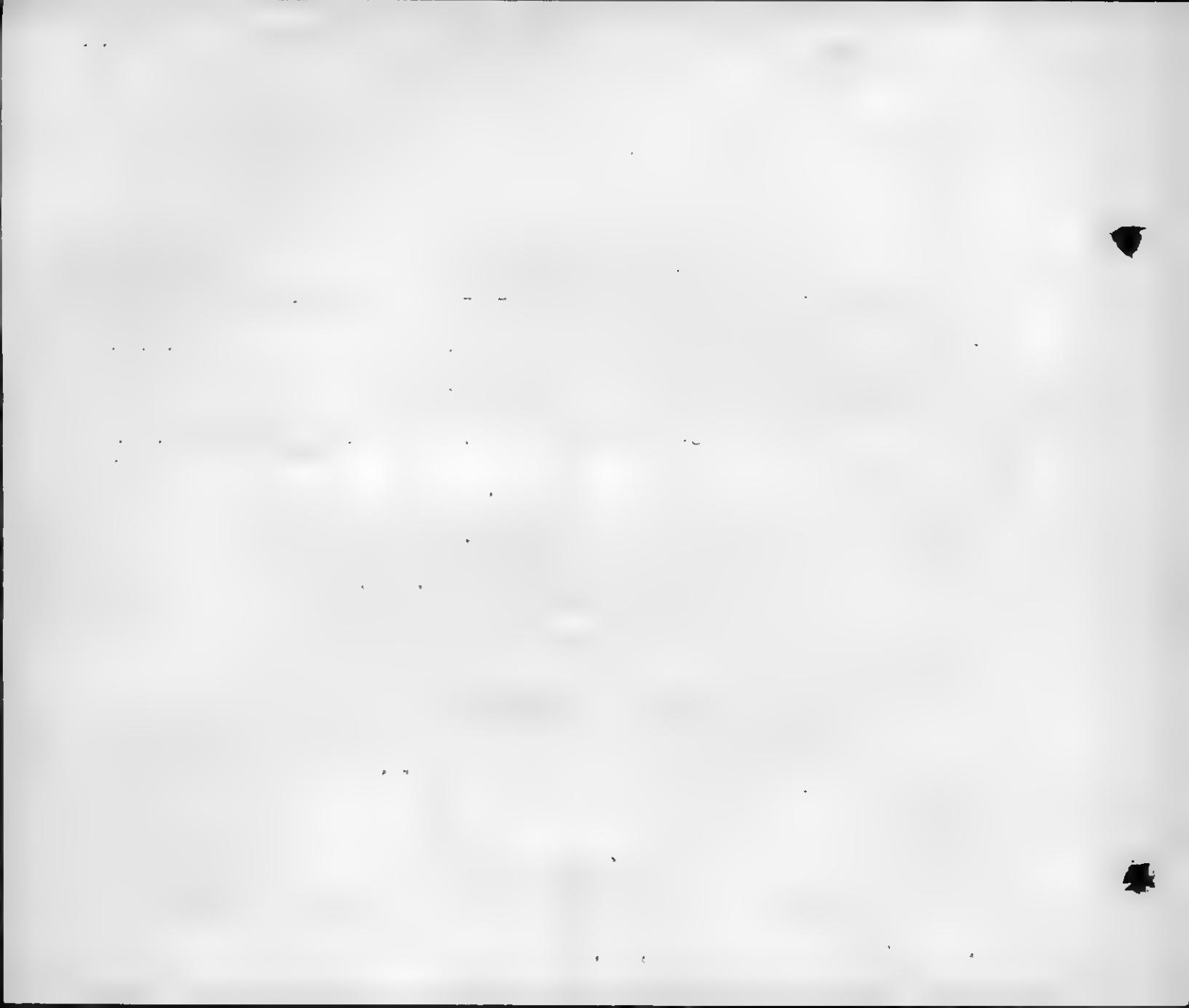
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8421

08415

1. PLACE OF DEATH a. COUNTY Prince George's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNT Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forrestville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS 8330 Leona Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ashley		First Hamilton	Middle 	Last Wood	4. DATE OF DEATH July 28 1961	Month July	Day 28	Year 1961
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-11	9. AGE (In years last birthday) 45 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Walter Francis Wood		14. MOTHER'S MAIDEN NAME Anna Mae Wood						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 223-16-5007		17. INFORMANT Ruby S. Wood		Address 2215 Wyngate Rd. SE, Bradbury Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] +90								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Purulent Meningitis (D. pneumonia) INTERVAL BETWEEN ONSET AND DEATH 24 hours								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Empyema, right lung (D. pneumonia)		48 hours				
DUE TO (c) Lobar pneumonia, right lung. (D. pneumonia)		48 hours						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, p.m., from the causes and on the date stated above.								
22a SIGNATURE <i>W. Etienne</i>		M.D. ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		
22c PHYSICIAN'S NAME (Type) W. Etienne		22d. ADDRESS College St., Md 20506				22b DATE SIGNED 7-25-61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/1/61		23c. NAME OF CEMETERY OR CREMATORIUM Ceder Hill		23d. LOCATION (City, town, or county) Suitland, Maryland (State)		
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 3 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kline		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08416

8422		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's										
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb ?		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 7504 Finns Lane										
3. NAME OF DECEASED (Type or print) Andrew Herman Woody		First Middle Last	4. DATE OF DEATH July 28 1961	Month Day Year								
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH February 25, 1884	9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chief Purchasing Clerk & Engraving		10b. KIND OF BUSINESS OR INDUSTRY Bureau of Printing	11. BIRTHPLACE (State or foreign country) Asheville, North Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Jack Woody		14. MOTHER'S MAIDEN NAME Elizabeth Hippes										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Bessie S. Woody -		Address 7504 Finns Lane Lanham, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia - Aspiration</i> DUE TO <i>Cerebral Thrombosis with Lame</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> 23 days. DUE TO (c) <i>5 years.</i>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Jen</i>		(County) <i>5057</i>	(State) <i>Jul 28 1961</i>			
21. I certify that (I) (this hospital) attended the deceased from <i>Jun 27 1961</i> to <i>Jul 28 1961</i> , that (I) (we) last saw the deceased alive on <i>27 Jul 1961</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above												
22a. SIGNATURE <i>Thomas G. Maloney</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>28 Jul 61</i>									
22c. PHYSICIAN'S NAME (Type) <i>THOMAS G. MALONEY</i>		22d. ADDRESS <i>41814-71st Ave.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/31/1961		23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) Prince Georges County, Md.				(State)		
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.		ADDRESS				25a. REC'D BY REGISTRAR DATE JUL 31 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8423

08417

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. — Page 4 may be retained by the hospital or attending physician.		2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.	
3. PLACE OF DEATH COUNTY <i>Prince Georges</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince Georges</i>	
5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town), <i>Brent - Adelphi</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>	
6. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Twin Branch Nursing Home</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Sophia Telores Wright</i>		9. AGE (In years last birthday) <i>Feb. 16, 1882 79 yrs.</i> IF UNDER 1 YEAR Months <input type="checkbox"/> Deys <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Penns.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Frederick Binck</i>		14. MOTHER'S MAIDEN NAME <i>Louise Bort</i> Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Nursing Home Records</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. <i>Hypertensive Cardio-Vasc Disease</i>	
		Cerebral Hemorrhage Diseases Diabetes Mellitus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Renal Insufficiency</i>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 19, 59</i> to <i>July 17, 1961</i> , that (I) (we) last saw the deceased alive on <i>July 17, 1961</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.		22. DATE SIGNED <i>7-17-61</i>	
22a. SIGNATURE <i>R. H. Sandstrom</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>R. H. Sandstrom</i>		22d. ADDRESS <i>10202 Loriston Lane, Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/20/61</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet</i>		23d. LOCATION (City, town or county) (State) <i>Washington D. C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
25a. REC'D BY REGISTRAR <i>Arthur S. Trahan</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8424

08418

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Brenton Cheverly

c. LENGTH OF STAY IN lb

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Prince George's General Hospital

3. NAME OF
DECEASED
(Type or print)

First
Inez

Middle
Lucy

Last
Yeagley

4. DATE
OF
DEATH

Month
July

Day
2

Year
19 61

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

1/28/93

9. AGE (in years
last birthday)

68 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Cusic

14. MOTHER'S MAIDEN NAME

Lucy Graves

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

—

17. INFORMANT

Geoffe Herbert

Address
229 Maryland Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

422.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

CONGESTIVE HEART FAILURE

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

James I. Boyd

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

7-2-1961

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

7-5-1961

22c. NAME OF CEMETERY OR CREMATORIUM

Arlington Nat'l Cem.

22d. LOCATION (City, town, or county)

Arlington, Va

(State)

23. FUNERAL DIRECTOR

Gerald A. Mattingly

ADDRESS

3111 8th St.

DC

24a. REC'D BY REGISTRAR

DATE JUL 5 '61

Arthur S. Krause

24b. REGISTRAR'S SIGNATURE

TO DAY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If it cannot be done within 24 hours, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. AISME
SM 9/60

REFERENCES